Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ernest Prather

2. Date of Death (Month, Day, Year): January 6, 2001

3. Time of Death: 11:55 AM

4a. Facility Name (If not institution, give street and number): Mariner Health Care of Kensington

4b. City, Town, or Location of Death: Kensington, MD

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-24-0679

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-29-1922

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 7705 Pacer Court

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sanitation

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Robert Nelson

18. Mother's Name (First, Middle, Meiden Sumama): Lottie Newman

19a. Informant's Neme/Relationship (Type, Print): Joyce E. Allen/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7705 Pacer Court Landover, MD 20785

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Park Crematory

Date: 01/10/01

20c. Location - City or Town, State: Riverdale, MD

21. Signature of Funeral Service Licensee: ▶ Behra J. Jenkins

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. long cancer — 1 year

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcida 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner:** On the besis of examination and/or investigetion, In my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ MD

29c. License number: D0005 3528

29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D'Shea Henderson, MS 2309 Shorefield Road Calverton, MD 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE JULIA ROBINSON

2. Date of Death (Month, Day, Year): JANUARY 11, 2001

3. Time of Death: 04:29am

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 579 22 1843

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 24, 1925

9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 85 Hospital Road

10f. Zip Code: 20678

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Charles Henry Kramer, Sr.

18. Mother's Name *(First, Middle, Maiden Sumame)*: Lillian Mae Trego

19a. Informent's Neme/Relationship *(Type, Print)*: Paul F. Robinson / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 172, Friendship, MD 20758

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: So. Memorial Gardens | Date: 01-15-01

20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: ▶ William R Yeoman

22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that ceused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia — Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Urosepsis. — Due to (or as a consequence of): — 10 days.

c. — Due to (or as a consequenca of):

d.

Part fl. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part f.: Acute Renal Failure; Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medicel examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edwin Yonsenig MD

29c. Licensa number: D0027189

29d. Data signed *(Month, Day, Year)*: Jan, 11, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): P.O. Box 1289 WALDORF, MD 20604-1289

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signatura: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02003

Rowe, Phillip James

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phillip James Rowe
2. Date of Death: Month: January Day: 11 Year: 2001
3. Time of Death: 0055
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217 30 5580
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 5, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: W. Va.
10b. County: Berkeley
10c. City, Town or Location: Falling Waters
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 264 Imperial Way
10f. Zip Code: 25419
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver
16b. Kind of Business/Industry: Sanitary Disposal

17. Father's Name (First, Middle, Last): Daniel E. Rowe
18. Mother's Name (First, Middle, Maiden Surname): Edna Ida Lowman

19a. Informant's Name/Relationship (Type, Print): Betty L. Rowe Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 264 Imperial Way Falling Waters, W. Va. 25419

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Leitersburg Cemetery
Date: 1/13/01
20c. Location - City or Town, State: Leitersburg, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Facility: Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 2 days

Due to (or as a consequence of):
b. Hypertension. — ? yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Poorly controlled hyperlipidemia — ? yrs

Due to (or as a consequence of):
d. Poorly controlled Adult onset diabetes — ? yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Ventricular Fibrillation.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D56413
29d. Date signed (Month, Day, Year): 01/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANJAY SAXENA, M.D 3 Byrkit Drive Williamsport, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02004

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anita Marie RITTER

2. Date of Death Month Day Year: Jan. 15, 2001

3. Time of Death: 5:00 Am

4a. Facility Name *(If not institution, give street and number)*: 328 Brookline Avenue

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 204-40-3599

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 10, 1948

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Rasidance of Decedant

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 328 Brookline Avenue

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: civilian employee -personnel assistant

16b. Kind of Business/Industry: federal government

17. Father's Name *(First, Middle, Last)*: Glenn Myers

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Cramer

19a. Informant's Name/Ralationship *(Type, Print)*: David L. Ritter - husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 328 Brookline Ave., Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cametery, crematory or othar place)*: Spring Hill Cemetery

Data: 1/18/01

20c. Location - City or Town, State: Shippensburg, Pa.

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Endometrial Cancer — 18 months

Dua to (or as a consaquence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Dua to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case raferred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifiar: Michael J. McCormack M.D.

29c. License number: 041667

29d. Date signed *(Month, Day, Year)*: 1-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Rd. Hagerstown MD. 21742

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0248-033
CJ
Christine R. Swann

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a&27 per ME G792 030201 SS

Certificate of Death

Reg. No. 2001 02005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Christine R.Swann	January	14	2001	02:27 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-41-5354	1☐ M 2☒ F	22 Yrs.					11-29-78	Wash.DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Prince George	Seat Pleasant	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6306 Capon Street	20743	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yas 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Program Assistant	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Lawrence Swann	Angel M. Boone

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Angel M. Swann	6306 Capon St. Seat Pleasant,Md 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resurrection Cemetery	1-20-01	Clinton,Md

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Snead Funeral Home & Cremation Service 5732 Georgia Ave N.W. Washington,DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaese or condition resulting in death)
a. DILATED CARDIOMYOPATHY
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medicel examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Netural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(s) and manner es stated.
2☒ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E.	January 15, 2001

30. Nema snd sddress of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 18 2001	[signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cora Emma Simms
2. Date of Death: Month: January Day: 4 Year: 2001
3. Time of Death: 11:45 a.m.

4a. Facility Name (If not institution, give street and number): Cherry Lane Nursing Center
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-14-8360
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 13, 1918
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9001 Cherry Lane
10f. Zip Code: 20708
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John David Fidler
18. Mother's Name (First, Middle, Maiden Surname): Virgie Mary Straus

19a. Informant's Name/Relationship (Type, Print): William K. Simms, Jr. - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7830 Hanover Parkway, Apt. T4, Greenbelt, MD 20770

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery
Date: 1/9/2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Allen Hunt
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — 2 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis
Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John Margolis
29c. License number: D25430
29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Margolis, M.D., 13952 Baltimore Avenue, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02007

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Oscar K. Sume

2. Date of Death Month Day Year: January 8, 2001

3. Time of Death: 5:20 PM

4a Facility Name *(If not institution, give street and number)*: Prince Georges Community Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-58-3012

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 6, 1927

9. Birthplace *(State or Foreign Country)*: Turkey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 16407 Pointer Ridge Drive

10f. Zip Code: 20716

10g. Citizen of What Country?: Turkey

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) | College (1-4or 5+): 9+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Medical doctor/OBGYN

16b. Kind of Business/Industry: Medicine

17. Father's Name *(First, Middle, Last)*: Kayser Sayegh

18. Mother's Name *(First, Middle, Maiden Surname)*: Milia Nahhas

19a. Informant's Name/Reletionship *(Type, Print)*: Elda M. Sume wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16407 Pointer Ridge Dr., Bowie, Md. 20716

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cem. | Date: 01-13-01

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: Beall

22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the daath. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease — 4 years

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure, Anasarca, Carcinoma Lung, Chronic Obstructive lung disease, Renal Insufficiency, Pneumonia, Carcinoma Prostate

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the besis of axamination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Devore

29c. License number: D01852

29d. Date signed *(Month, Day, Year)*: January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(20)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria Szunyogh

2. Date of Death: Month January Day 6 Year 2001

3. Time of Death: 9:30 AM

4a. Facility Name (If not institution, give street and number): 17730 Mill Branch Pl.

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 212-34-5447

6. Sex: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Jun 14 1924

9. Birthplace (State or Foreign Country): Hungary

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☒ Yes 2☐ No XX

10e. Street and Number: 17730 Mill Branch Pl.

10f. Zip Code: 20716

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No XX If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 6

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Crest Hill Draperies

17. Father's Name (First, Middle, Last): Peter Radl

18. Mother's Name (First, Middle, Maiden Surname): Anna Pravitz

19a. Informant's Name/Relationship (Type, Print): Jozsef Szunyogh (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17730 Mill Branch Pl. Mitchellville, MD 20716

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Gate Of Heaven Cemetery

Date: 1/10/01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction — minutes

Due to (or as a consequence of):

b. Diffuse Coronary Atherosclerosis — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertensive Cardiovascular disease — yr

Due to (or as a consequence of):

d. — × — × —

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia, Congestive heart failure, Paroxysmal Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D24720

29d. Date signed (Month, Day, Year): 01-08-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. Reys TAG 6132 Loudoven Road, Chevorley Md 20785-

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02009

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lavonia F. Thomas-Snow
2. Date of Death — Month: January Day: 6 Year: 2001
3. Time of Death: 7:54PM
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-58-0645
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 12, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1001 Longleaf Road
10f. Zip Code: 20743
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grada completed)*: Elemantery/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use ratired)*: Translator
16b. Kind of Business/Industry: Defense Language Institute/Government

17. Father's Name *(First, Middle, Last)*: John William Fields
18. Mother's Neme *(First, Middle, Maidan Sumama)*: Ethel Cooper

19a. Informant's Name/Relationship *(Type, Print)*: Andree Thomas - Daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1001 Longleaf Rd., Capitol Heights, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Lincoln Memorial Cem.
Date: 1/16/2001
20c. Location - City or Town, Steta: Suitland, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name end Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. Lisf only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart failure — weeks
Due to (or as a consequence of):
b. Coronary artery disease — Months

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other signifícant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: Surinder Singh
29c. License number: D28920 Maryland
29d. Date signed *(Month, Day, Year)*: 1/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURINDER SINGH 7319A Hanover Pkwy. Greenbelt MD, 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02010

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Ellen Shegogue
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 9:45 pm
4a. Facility Name *(If not institution, give street and number)*: Crescent Cities Center
4b. City, Town, or Location of Death: Riverdale
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-32-8361
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 4, 1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4409 East West Highway
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Henry Malcolm Blythe, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Olive P. Watkins
19a. Informant's Name/Relationship *(Type, Print)*: Ronald S. Shegogue - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10801 Javins Street, Glenn Dale, MD 20769
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
Date: 01/13/01
20c. Location - City or Town, State: Brentwood, Maryland
21. Signature of Funeral Service Licensee: Dorothy Jean Wirt
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia. — Days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Failure to Thrive Adult.
Progressive muscle weakness
Hypertensive Cardiovascular Disease.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N Shai M.D
29c. License number: D48213
29d. Date signed *(Month, Day, Year)*: January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neelam Ashai, M.D., 4410 74th Avenue, Landover Hills, MD 20784

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02011

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Otto Shlagel

2. Date of Death Month Day Year: January 7, 2001

3. Time of Death: 3:09 A.M.

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-12-7739

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 28, 1911

9. Birthplace *(State or Foreign Country)*: Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5602 Sargent Road

10f. Zip Code: 20782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Baker

16b. Kind of Business/Industry: Bakery

17. Father's Name *(First, Middle, Last)*: unobtainable

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Schwingenschloegl

19a. Informant's Name/Relationship *(Type, Print)*: Freida Shlagel / Spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5602 Sargent Rd. Hyattsville, MD 20782

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery

Date: January 11,

20c. Location - City or Town, State: 2001 Brentwood, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. coronary artery disease — years

Due to (or as a consequence of):

b. Atherosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D42403

29d. Date signed *(Month, Day, Year)*: 1/7/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAT MATHUR 106 Irving Street, NW, Washington DC 20010

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert Fleming Stewart

2. Date of Death: Month January Day 8, Year 2001

3. Time of Death: 9:25 pm

4a. Facility Name (If not Institution, give street and number): Collington Episcopal Life Care Center

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-05-5172

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28, 1905

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10450 Lottsford Road, #222

10f. Zip Code: 20721

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Repairing

17. Father's Name (First, Middle, Last): George Thomas Stewart

18. Mother's Name (First, Middle, Maiden Surname): Sallie Waymack

19a. Informant's Name/Relationship (Type, Print): Margaret D. Farthing - Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 4482, Rockville, MD 20847

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 01/12/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Dorothy Jean Witt

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebrovascular Accident	30 minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation; Congestive Heart Failure.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Will Dorf

29c. License number: 047603

29d. Date signed (Month, Day, Year): 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4000 Mitchellville Rd B316 Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrar's Signature: Sandra B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(15)

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0153-033

WILLIAM STEWART

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02013

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Clark Stewart

2. Date of Death Month Day Year: JANUARY 9, 2001

3. Time of Death: 3:20P.M.

4a. Facility Name *(If not institution, give street and number)*: 10305 ROLAND LANE

4b. City, Town, or Location of Death: FT. WASHINGTON

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-82-8387

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 9, 1962

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10305 Roland Lane

10f. Zip Code: 20744

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1979-1980

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fire Fighter

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Robert Alexander Stewart, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Flora Louise Dickerson

19a. Informant's Name/Relationship *(Type, Print)*: Flora L. Stewart (Mother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10305 Roland Lane Ft. Washington, MD 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland State Veterans Cem.

Date: Jan 17, 2001

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ Kelli R. Pattee

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carbon Monoxide Poisoning

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other *(Specify)* SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month/Day/Year)*: Found 1-9-01

28b. Time of Injury: Found 1515 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: asphyxiated with hose connected to exhaust pipe

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 10305 Roland Lane Fort Washington, MD

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J. Chute

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: ▶ Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6 IVa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02014

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILBUR CALVIN SNOOTS
2. Date of Death Month / Day / Year: January 10, 2001
3. Time of Death: 1255 PM
4a. Facility Name *(If not institution, give street and number)*: Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-16-0676
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 18, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1900 Rosemont Avenue
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Car Man
16b. Kind of Business/Industry: Railroad

17. Father's Name *(First, Middle, Last)*: Harry Calvin Snoots
18. Mother's Name *(First, Middle, Maiden Surname)*: Daisy Myrtle Virts

19a. Informent's Name/Relationship *(Type, Print)*: Patti Clark (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 248 South Carroll Street, Frederick, MD 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery — Date: 1/12/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Hypertensive Cardiovascular disease — 10 yrs.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert L. Kaufmann
29c. License number: D-13971
29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufmann, MD 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#20b 01/16/2001 FCHD KS

Certificate of Death

Reg. No 2001 02015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SYLVIA A. SIMS

2. Date of Death: Month JANUARY Day 10 Year 2001

3. Time of Death: 3:00 AM

4a. Facility Name (If not institution, give street and number): WILSON HEALTH CARE CENTER

4b. City, Town, or Location of Death: GAITHERSBURG

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-09-1000

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 25 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Myersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3702 A Brethren Church Road

10f. Zip Code: 21773

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Mills

18. Mother's Name (First, Middle, Maiden Surname): Bertie West

19a. Informant's Name/Relationship (Type, Print): James S. Sims / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3702 A Brethren Church Rd, Myersville, Md. 21773

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Oak Cemetery

Date: 1/15/01 ~~1/15/00~~

20c. Location - City or Town, State: Gaithersburg, Md.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia — Approximate Interval: days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Steven Dolinsky

29c. License number: 20148

29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dolinsky MD 911 Russell Ave, Gaithersburg Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02016

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa Ann Smith

2. Date of Death: Month January Day 13 Year 2001

3. Time of Death: 5:40 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-82-6601

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 23,1965

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1405 Wooden Bridge Lane

10f. Zip Code: 21771

10g. Citizen of What Country? United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dietary Consultant

16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): Howard Eugene Smith

18. Mother's Name (First, Middle, Maiden Surname): Doris Virginia Holsey

19a. Informant's Name/Relationship (Type, Print): Doris Smith/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1405 Wooden Bridge Lane, Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Simpson U. M. Cemetery | Date: 1/17/2001

20c. Location - City or Town, State: Mt. Airy, Maryland

21. Signature of Funeral Service Licensee: ▶ Isabel D Wagner

22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic colon cancer — 9 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Acute renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D0035267

29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Manuel Casiano 74 Thomas Johnson DR, Frederick, MD 21702.

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02017

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
FLOYD	EDWIN	SCHLUETER SR.	JANUARY 15, 2001	14:07

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
477 12 9531	1☒ M 2☐ F	79 Yrs.			Jan 11, 1922	Minnesota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Chesapeake Beach	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7785 Dentzel Court	20732	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-45	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	agent & credit union officer	Internal Revenue Svc.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Julius Schlueter	Lydia Helen Drawz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Annamae Odum Schlueter, wife	same as # 10 a-f

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	01-19-01	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William R. [illegible]	Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	MINUTES
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORONARY ARTERY DISEASE	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, HIP FRACTURE, HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ John H Weigle MD	D26358	JAN. 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JOHN WEIGLE, MD PRINCE FREDERICK, MD 20678

20+1

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Smith

2. Date of Death: Month January Day 9, Year 2001

3. Time of Death: 7:35 A.M.

4a. Facility Name (If not institution, give street and number): Calvert County Nursing Center

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 218-38-8785

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 9, 1921

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Sunderland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 915 Lower Marlboro Road

10f. Zip Code: 20689

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Someone Else's Home

17. Father's Name (First, Middle, Last): Hoover Hall

18. Mother's Name (First, Middle, Maiden Surname): Rachel Holland

19a. Informant's Neme/Relationship (Type, Print): Joyce Smith/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1360 Peabody St. NW #306 Washington, D.C. 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Hope UMC Cemetery

Date: 1/15/01

20c. Location - City or Town, State: Sunderland, MD

21. Signeture of Funeral Service Licansee: ▶ Gladys A. Sewell

22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Gangrene toes.

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Severe Peripheral Vasc. disease

Due to (or es e consequence of):

d. dementia, Cancer lung

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Kioumarce Yazdani

29c. License number: D71168

29d. Date signed (Month, Day, Year): 1/10/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Kioumarce Yazdani, M.D. Huntingtown, MD 20639

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registrer's Signature: ▶ Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02019

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vivian Mae SEAL
2. Date of Death Month Day Year: January 12 2001
3. Time of Death: 2050
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-28-9123
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 2, 1933
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16236 Broadfording Road
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sole Cementer
16b. Kind of Business/Industry: Shoe Factory

17. Father's Name *(First, Middle, Last)*: Charles J. Butts
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Lowman

19a. Informant's Name/Relationship *(Type, Print)*: Kenneth L. Seal - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16236 Broadfording Road Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenlawn Memorial Park
Date: 1/16/01
20c. Location - City or Town, State: Williamsport, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Respiratory Distress Syndrome	3weeks
Due to (or as e consequence of):	b. Pneumonia	4 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or es a consequence of):	c. Congestive Heart Failure	4 weeks
Due to (or es e consequence of):	d. Coronary artery Disease	Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D44996
29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO, MD 21713

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

VIVIAN SEAL Time of death 2050 January 12, 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilson Elwood Stevens
2. Date of Death Month / Day / Year: January 12 2001
3. Time of Death: 1457
4e. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-01-5705
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 14, 1914
9. Birthplace *(State or Foreign Country)*: Penna.

Usual Residance of Decedent

10e. State: Penna.
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4215 Sportsman Rd.
10f. Zip Coda: 17225
10g. Citizen of What Country?: U.S.A.
11. Meritel Stetus: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yes, Giva Yaar or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White
15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 6 — Collega (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Locomotive Engineer
16b. Kind of Businass/Industry: B & O Railroad
17. Father's Name *(First, Middle, Last)*: Emmert Stevens
18. Mother's Nama *(First, Middle, Maiden Sumama)*: Avis Virginia Hoover
19a. Informant's Name/Reletionship *(Type, Print)*: Carol J. Hudler/Daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1423 Moosic Dr. Chambersburg, Pa. 17201
20a. Mathod of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Piaca of Disposition *(Nama of cematary, cramatory or other place)*: Welsh Run Church Of The Brethren Cemetery
Data: 1/16/01
20c. Localion - City or Town, Stata: Welsh Run, Pa.
21. Signatura of Funeral Service Licensee: H. Martin Zimmerman Jr.
22. Nama and Addrass of Fecility: Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that ceused tha daath. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on each lina. — Approximate Interval Between Onset and Death

Immediata Causa (Final disaesa or condition resulting in death)
a. adynamic ileus
Due to (or as a consequance of):
b. end stage renal disease on hemodialysis

Sequentially list conditions, if any, laeding to immadiata ceuse. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last
Dua to (or as a consequanca of):
c. spinal stenosis s/p L3-4 Lamenectomy
Dua to (or as a consequanca of):
d. diabetes militus

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa raferred to medical examinar? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To tha best of my knowledga, daath occurred at the time, data and place, end due to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to tha cause(s) and mannar stated.
29b. Signatura and titla of certifiar: [illegible] MD
29c. License number: BY6111023
29d. Data signed *(Month, Day, Year)*: January 12, 2001
30. Nama and address of person who completed ceuse of daath (Item 23a) (Typa, Print): [illegible] 12931 Oak Hill Ave Hagerstown, Md. 21742

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signatura: [illegible] D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Stevens, Wilson

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02021

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GLENN EUGENE STAINS
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 0100
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 219-12-2004
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 22, 1927
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 321 Chartridge Drive
10f. Zip Coda: 21742
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Evar in U.S. Armed Forces?: 1☒ Yas 2☐ No — If Yas, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Rece - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Salesman
16b. Kind of Businass/Industry: Furniture Company

17. Father's Nema *(First, Middle, Last)*: John Franklin Stains
18. Mother's Nama *(First, Middle, Maiden Surnama)*: Gladys Pearl Stover

19a. Informant's Name/Ralationship *(Type, Print)*: M. Glenda Traverso/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 19671 Brassie Place, Gaithersburg, Maryland 20886

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, crematory or othar placa)*: Rest Haven Cemetery
Data: Jan. 19
20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signatura of Funaral Service Licensee: ▶ [signature]
22. Nama and Addrass of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hasrt failura. List only ona ceusa on aach lina.

		Approximata Interval Between Onsat and Daath
Immediate Causa (Final diseesa or condition resulting in death) a.	Cardiorespiratory Failure	Few days
	Dua to (or as a consequance of): Staph Aureus Septicemia	Few days
Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last b.		
	Dua to (or as a consequence of): Pneumonia Bilateral	Few days
c.		
	Dua to (or as a consequanca of): Congestive Heart Failure	Few years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

End Stage Renal Failure

Anemia, Diabetes Mellitus

Coronary Artery Disease

23b. Did tobacco uas contribute to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case rafarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Place of Injury - At homa, ferm, straat, factory, office building, etc. *(Specify)*
28b. Tima of Injury: M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Data of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, date and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the cause(s) and mannar statad.

29b. Signatura and title of Certifier: ▶ [signature] MD
29c. License number: D35497
29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): Tanvir A. Pasha, M.D. 376 Mill St. Hagerstown, Maryland 21740

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0157-033

ELMO

TOLBERT AMENDED ITEMS# 23a,pt II,& 27 per M.E. G792 020701 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ELMO TOLBERT , JR.	JANUARY 9, 2001	2:05P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL	CLINTON	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
413-82-0722	1 [X] M 2 [ ] F	49 Yrs.			April 16, 1951	Tennessee

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Temple Hills	[X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3901 Spring Terrace	20748	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Personnel Specialist	United States Army

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elmo Tolbert	Cora Bolton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charlotte Virginia Tolbert (Wife)	3901 Spring Terrace Temple Hills, Maryland 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Maryland Veterans Cemetery	1-17-2001	Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Janet C. Anderson

22. Name and Address of Facility: ROLLINS FUNERAL HOME, INC. 4339 Hunt Place, N.E. Washington, D.C. 20019

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE PNEUMONIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Dennis J Clute MD	O.C.M.E.	JANUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	Penny B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Dorothy	Louise	Tyson	January 5, 2001	2:33AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-42-9801	1☐ M 2☒ F	82 Yrs.			Sept. 13, 1918	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Temple Hills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4935 Temple Hills Road	20748	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
6th	N/A	Day Care	Child Care Center

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Harry Beckert	Catherine (Unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Morris Edward Tyson (Son)	4935 Temple Hills Road Temple Hills, MD 20748

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Washington Naiontal Cemetery	Jan. 10, 2001	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Respiratory Failure	3 weeks
Due to (or as a consequence of):	b. Exacerbation of chronic obstructive pulmonary disease	3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequenca of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No N/A

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sam Tellawi	D34274	1.05.2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Sam Tellawi M.D. 7700 Old Branch Avenue #B102 Clinton, Maryland 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Tyson, Dorothy 01/05/2001 @ 2:33 Am

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02024

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ricardo Louis Toomer
2. Date of Death Month Day Year: 01-03-2001
3. Time of Death: 10:15 AM
4a. Facility Name *(If not institution, give street and number)*: 2608 Afton St.
4b. City, Town, or Location of Death: Temple Hills
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-54-0579
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 07 11 1941
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2608 Afton Street
10f. Zip Code: 20748
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nursing Assistant
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: William Toomer
18. Mother's Name *(First, Middle, Maiden Surname)*: Golden Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Gelena Toomer/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2608 Afton Street Temple Hills, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans cemetery
Date: 1-12-01
20c. Location - City or Town, State: Cheltenham,MD

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic adenocarcinoma lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Richard Palmer
29c. Licensa number: D0055120
29d. Date signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Palmer, M.D. 1328 Southern Ave. S.E. Suite 310 Washington, DC 20032

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Bernice D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02025

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOUIS H. THOMPSON
2. Date of Death (Month, Day, Year): January 3, 2001
3. Time of Death: 11:45 A.M.
4a. Facility Name *(If not institution, give street and number)*: SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 056-18-7393
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 27, 1923
9. Birthplace *(State or Foreign Country)*: New York, N.Y.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10923 Flintlock Lane
10f. Zip Code: 20744
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: Yes
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* African American
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Yard Master
16b. Kind of Business/Industry: (N.Y.City Transit Authority) Government
17. Father's Name *(First, Middle, Last)*: James Thompson
18. Mother's Neme *(First, Middle, Meiden Sumeme)*: Mary (Unknown)
19a. Informant's Name/Relationship *(Type, Print)*: Dolores Hawkins - Step-daughter
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 10923 Flintlock Lane, Ft. Washington, MD 20744
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Garden of Faith Cemetery
Date: 1/8/2001
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: John T. Stewart III
22. Neme and Address of Facility: STEWART FUNERAL HOME, Inc., 4001 Benning RD, N.E. Wash., D.C.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. VENTRICULAR ARRHYTHMIAS — FIVE MINUTES

Due to (or as a consequenca of):
b. SEPSIS SYNDROME — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as e consequence of):
c. INFECTED DECUBITUS — 2 MONTHS

Due to (or as e consequence of):
d. SEVERE PERIPHERAL NEUROPATHY — 4 YRS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END STAGE RENAL DISEASE
HYERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to compietion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicai examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Couid not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, streel, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Pamela Cuha M.D.
29c. License number: D0016116
29d. Date signed *(Month, Day, Year)*: 01/05/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAMELA CUHA M.D., 8926 WOODYARD ROAD #501 CLINTON MD 20735

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(5)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02026

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN B. TYSON

2. Date of Death Month Day Year: JAN 14 2001

3. Time of Death: 2:05pm

4a. Facility Name *(If not institution, give street and number)*: FOREST GLEN NURSING HOME

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-10-3705

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: APRIL 22 1912

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2700 BARKER ST.

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast greda completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: CLARENCE C. OFFUTT

18. Mother's Name *(First, Middle, Maiden Surname)*: LUCILE CLEMENTS

19a. Informant's Name/Relationship *(Type, Print)*: MARY BUTTS/SISTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3200 BAKER CIRCLE, ADAMSTOWN, MD 21710

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ENDERS/SHIRLEY FH

Date: 1/17

20c. Location - City or Town, State: BERRYVILLE, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HILTON FUNERAL HOME
BOX 86, BARNESVILLE, MD 20838

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — 5 yrs

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Myron L Lenkin

29c. License number: D06674

29d. Data signed *(Month, Dey, Year)*: Jan 16 2001

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): MYRON L. LENKIN MD 2309 SHORFIELD RD WHEATON MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 16 2001

32. Registrar's Signeture: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02027

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSS HOTCHKISS THOMSON

2. Date of Death Month: JANUARY Day: 11, Year: 2001

3. Time of Death: 12:35 AM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 105-01-2809

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 7, 1917

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mount Airy

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 706 Midway Avenue

10f. Zip Code: 21771

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Records Officer

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: William W. Thomson

18. Mother's Name *(First, Middle, Maiden Surname)*: Greta Hotchkiss

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth Thomson / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 706 Midway Avenue Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hagerstown Crematory

Date: Jan, 13 2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIOMYOPATHY — UNKNOWN

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — UNKNOWN

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE + CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ George L. Smith, M.D. VPMA

29c. License number: D 10587

29d. Date signed *(Month, Day, Year)*: 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE L. SMITH, M.D. VICE-PRES MED AFFAIRS FREDERICK MEMORIAL HOSP. FREDERICK, MD. 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS VERA TURNER
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 6:30 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: MOntgomery

Funeral Director

5. Social Security Number: 232-01-8674
8. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 19, 1919
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 510 Pearl Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Elmer Braithwait
18. Mother's Name (First, Middle, Maiden Surname): Madeline Albert

19a. Informent's Name/Relationship (Type, Print): James E. Turner (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 Pearl Street, Frederick, MD 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Resthaven Mem. Gardens
Date: 1/16/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E Dailey Jr
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death): a. ISCHEMIC AND VALVULAR HEART DISEASE — YEARS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

PERIOPERATIVE CEREBROVASCULAR ACCIDENT

RESPIRATORY FAILURE

SEPSIS

23b. Did tobacco use contribute to the causes of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: Joseph B. Mizgerd, M.D.
29c. License number: D08425
29d. Date signed (Month, Day, Year): JANUARY 14, 2001

30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): JOSEPH B. MIZGERD M.D. 7600 CARROLL AVE, TAKOMA PARK MD 20912

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02029

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETHANY ANN TRIMMER
2. Date of Death: Month JANUARY Day 15 Year 2001
3. Time of Death: 2:50 PM
4a. Facility Name (If not institution, give street and number): 3405 HARPERS FERRY ROAD
4b. City, Town, or Location of Death: SHARPSBURG
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 212-41-8375
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 7 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 26, 1993
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: SHARPSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3405 HARPERS FERRY ROAD
10f. Zip Code: 21782
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NEVER EMPLOYED
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): MICHAEL S. TRIMMER
18. Mother's Name (First, Middle, Maiden Surname): MICHELLE L. NEW

19a. Informant's Name/Relationship (Type, Print): MICHAEL S. TRIMMER/FATHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 HARPERS FERRY ROAD, SHARPSBURG, MARYLAND 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): SAMPLES MANOR CEMETERY
Date: 1/18/01
20c. Location - City or Town, State: SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee: ▶ P. Steven Danfelt Jr. P. St Danfelt, Jr.
22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiorespiratory Arrest.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Neuronal Ceroid Lipofuscinosis.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Angela M Tamayo MD
29c. License number: D52295
29d. Date signed (Month, Day, Year): 1-16-01.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 313 West Memorial Blvd. Hagerstown MD 21740

State Registrar

31. Date filed (Month, Day, Year): 1-16 JAN 16 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 020030

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mattie Lou Vaughan

2. Date of Death: Month January Day 05 Year 2001

3. Time of Death: 0200

4a. Facility Name (If not institution, give street and number): Waterview Health Care 105 Times Square

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 579-14-5834

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 15, 1916

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Ocean View

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 204 Bayfront Drive

10f. Zip Code: 19970

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+): N/A

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Waitress

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Samuel Vaughan

18. Mother's Neme (First, Middle, Maiden Sumeme): Trolina Smith

19e. Informent's Neme/Relationship (Type, Print): Louis Samuel Vaughn (Nephew)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Bayfront Drive Ocean View Delaware 19970

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Lee Crematory | Date: January 10, 2001

20c. Location - City or Town, Stete: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Feciility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final disease or condition resulting in deeth): a. metastatic breast cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditione** contributing lo death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and placa, end due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nathan

29c. License number: D47094

29d. Date signed (Month, Dey, Year): 1/5/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): NATESTA, V 106 PINE BLUFF ROAD SALISBURY MD 21801

State Registrar

31. Dete filed (Month, Dey, Year): JAN 12 2001

32. Registrar's Signeture: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPS
01-0186-033
DEVON WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 23a,b,c,27 per ME G793 032801 SS

Certificate of Death

Reg. No. 2001 02031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Devon Chenique Williams
2. Data of Death: Month January, Day 11, Year 2001
3. Time of Death: 11:35 AM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 577-02-9622
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 4/3/79
9. Birthplace (State or Foreign Country): Cheverly, MD

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10059 Campus Way South
10f. Zip Code: 20774
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Danny R. Williams
18. Mother's Name (First, Middle, Maiden Surname): Carolyn P. Stewart

19a. Informant's Name/Relationship (Type, Print): Carolyn P. Williams Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10059 Campus Way South, Upper Marlboro, MD 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Peter's Church Cem.
Date: 1/17/01
20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: Dina Mikell
22. Name and Address of Facility: Pope Funeral Home, 5538 Marlboro Pike, FV, MD 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY ARREST
Due to (or as a consequence of):
b. DIFFUSE ALVEOLAR DAMAGE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. SICKLE CELL DISEASE AND ASTHMA
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jason Cockett, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 12, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jason Cockett, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02032

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Annie Lee Weakley

2. Date of Death — Month: January Day: 4, Year: 2001

3. Time of Death: 12:30 pm

4a. Facility Name *(If not institution, give street and number)*: Larkin Chase Nursing Home

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-05-2585

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct. 19, 1913

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Rasidance of Decedent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 610 Ellsworth Drive

10f. Zip Code: 20910

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)* — Elamentary/Secondary (0-12): 12 — Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Secretary

16b. Kind of Businass/Industry: Western Electric

17. Father's Nama *(First, Middla, Last)*: Haywood Seattle

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Onella Seattle

19a. Informant's Name/Ralationship *(Type, Print)*: Linda Marie Sherwood: Great Niece

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 610 Ellsworth Drive, Silver Spring, Maryland 20910

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: Metropolitan Crematory

Data: 01/05/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Dorothy Dean Watts

22. Nama and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Entar tha disaasa or complications that ceusad the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach line.

Approximata Intarval Batwaan Onsat and Death

Immediate Causa (Final disaasa or condition resulting in daath)

a. Atherosclerotic Heart Disease — Years

Dua to (or as a consaquance of):

b. Dementia — Years

Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in death) Last

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of ceusa of daath? 1☐ Yas 2☒ No

25. Was cesa rafarrad to madical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of cartifiar: Rakesh Arora

29c. Licansa number: D20108

29d. Data signad *(Month, Day, Year)*: 1/5/01

30. Nama and addrass of parson who complatad ceusa of daath (Item 23a) (Type, Print): Rakesh Arora, M.D. 14300 Gallant Fox Lane #222, Bowie, Maryland 20715

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 08 2001

32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02033

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Katherine Williams
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 2:15 A.M.
4a. Facility Name *(If not institution, give street and number)*: Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-32-0840
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 6, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 217 Aragona Drive
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); 3 College (1-4or 5+)
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Healthcare

17. Father's Name *(First, Middle, Last)*: Joseph Peter McGuigan
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Nora Richards

19a. Informant's Name/Relationship *(Type, Print)*: Cecilia Martin - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9905 Greening Court, Dunkirk, Maryland 20754

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: 01-12-2001
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Road, Oxon Hill, Maryland 20745

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Septic Shock — 8 days

Due to (or as a consequence of):
b. SmALl bowel infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. mesenteric Artery occlusion
Due to (or as a consequence of):
d. atrial fibrillation

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deidra L. Varner MD
29c. License number: D33512
29d. Date signed *(Month, Day, Year)*: 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEIDRA L. VARNER, MD; 11701 Livingston Rd, #101; Ft. Washington Md 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR J. WHITE JR.
2. Date of Death: Month JANUARY Day 3, Year 2001
3. Time of Death: 5:30am
4a. Facility Name (If not institution, give street and number): 8605 Magnolia Drive
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 213-22-0063
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 15, 1928
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 8605 Magnolia Drive
10f. Zip Code: 20706
10g. Citizen of What Country? United States America

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Arthur White
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Barnard

19a. Informant's Name/Relationship (Type, Print): Michael White/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1020 Shenandoah Street Harrisonburg VA 22802

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory
Date: 01/06/2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Fort Lincoln Funeral Home, 3401 Bladensburg Road Brentwood Maryland 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 10yrs
Due to (or as a consequence of): b. Severe Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. Chronic Tobacco Abuse
Due to (or as a consequence of): d. Emphysema

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D26873
29d. Date signed (Month, Day, Year): 1 5 01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5504 Baltimore Ave Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: [signature] P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #8, 10C, 18 PER INFORMANT 3792 2-15-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MARGARET	LOUISE	WARREN	JANUARY	4,	2001	6:15 a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FAIRFIELD NURSING HOME	CROWNSVILLE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-07-4688	1☐ M 2☒ F	87 Yrs.			05-08-~~1913~~ 1914	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	CHARLES	~~URONSIDE~~ IRONSIDE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
RT.1, BOX 415	20640	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		COSMOTOLOGY	N/A

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
EDWARD	NEWMAN	BERTHA	~~MATTHEWS~~ MATHEWS

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOYCE JOHNSON - DAUGHTER	8075 LEROY PLACE, INDIAN HEAD, MD 20640

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	RESURRECTION CEMETERY	01-10-01	CLINTON, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. C. Taylor	TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Gastrointestinal Bleed	2 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Thrombocytopenia	2 weeks
	Due to (or as a consequence of):	
	c. Pneumonia	2 weeks
	Due to (or as a consequence of):	
	d. Dementia	3 yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D40519	1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Misza M. Nusairee, 7845 Oakwood Prof. Bldg, Glen Burnie, 21061 - Maryland

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 09 2001	Bernice B. Sparks

State Registrar

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARVEY CHARLES WILLIAMS

2. Date of Death (Month, Day, Year): JAN. 6, 2001

3. Time of Death: 9:15 PM

4a. Facility Name (If not institution, give street and number): NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-10-5824

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 18, 1914

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9701- VEIRS DR.,

10f. Zip Code: 20850

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXPEDITER

16b. Kind of Business/Industry: UNKNOWN

17. Father's Name (First, Middle, Last): WALTER WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname): MINNIE MAY

19a. Informant's Name/Relationship (Type, Print): REV.DR. REICHARD-EXECUTOR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701- VEIRS DR., ROCKVILLE,MD.20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FORREST CEM. | Date: 1/16/

20c. Location - City or Town, State: OWINGS MILL,MD.

21. Signature of Funeral Service Licensee: ▶ W. M. Tyson

22. Name and Address of Facility: Hysong Co.,Inc. 6510- 16th St.,NW, Wash.,DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Atrial Fibrillation	5 years
Due to (or as a consequence of): b.	Congestive heart Failure	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Arteriosclerotic Coronary Artery Disease	30 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer of Prostate, Myeloproliferative Disorder

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D36618

29d. Data signed (Month, Day, Year): January 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. C. SCHEMM- 9701- VEIRS DR., ROCKVILLE,MD.

State Registrar

31. Data filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(3)

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02037

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patrick Joseph Wilson
2. Date of Death (Month, Day, Year): JAN 7, 2001
3. Time of Death: 7:41PM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 227-64-1702
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 20, 1945
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1561 Eton Way
10f. Zip Code: 21114
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Merried 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Systems Analyst
16b. Kind of Business/Industry: US Gov't

17. Father's Name *(First, Middle, Last)*: Edward John Wilson
18. Mother's Name *(First, Middle, Maiden Surname)*: Antoinette O'Connor

19a. Informant's Name/Relationship *(Type, Print)*: Judy L. Wilson wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1561 Eton WAy, Crofton, Md. 21114

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Our Lady of the Fields Cem. Date: 01-11-01
20c. Location - City or Town, Stete: Millersville, Md.

21. Signeture of Funeral Service Licensee: D R Beall
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. CRain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Telesforo Reyes MD PATHOLOGIST
29c. License number: D0014816
29d. Date signed *(Month, Day, Year)*: Jan. 09, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Telesforo G. Reyes, Jr., M.D. North Arundel Hospital 301 Hospital Dr., Glen Burnie, Md. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: Bonnie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(10)

Pt WILSON PATRICK J

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Reginald Cottrell Wise, Sr.

2. Date of Death: Month January, Day 6, Year 2001

3. Time of Death: 20:30

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-68-5895

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 14, 1951

9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 2007 Chita Ct.

10f. Zip Code: 20748

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Eddie Wise

18. Mother's Name (First, Middle, Maiden Surname): Rose Ann Mahoney

19a. Informant's Neme/Relationship (Type, Print): Reginald C. Wise, Jr. - Son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2007 Chita Ct., Temple Hills, MD 20748

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Harmony Memorial Park

Date: 1/11/2001

20c. Location - City or Town, State: Landover, MD

21. Signature of Funerel Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema. — 2days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery disease.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D46478

29d. Date signed (Month, Day, Year): 1-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sukesh A. Patel, 7501 Surratts Rd #307, Clinton MD 20735

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Regina B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Expired 1-6-01 @ 20:30 Dr. S. Patel

Wise, Reginald #99342

18

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephen Wayne Williams
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 7:00pm
4a. Facility Name (If not institution, give street and number): 8505 Shorthills Dr.
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 438-25-1624
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 32 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 29, 1968
9. Birthplace (State or Foreign Country): Alexandria, La.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8505 Shorthills Dr.
10f. Zip Code: 20735
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Leon Williams
18. Mother's Name (First, Middle, Maiden Surname): Helen Thomas

19a. Informant's Name/Relationship (Type, Print): Helen Williams / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1534 Dallas Ave. Alexandria, La. 71301

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garden of Memories
Date: 1/17/01
20c. Location - City or Town, State: Alexandria, La.

21. Signature of Funeral Service Licensee: [signature] 01/08/01
22. Name and Address of Facility: Alexander S. Pope Funeral Homes, 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary failure — days
Due to (or as a consequence of):
b. Hodgkins lymphoma — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: [signature] MD
29c. License number: MA#156828
29d. Date signed (Month, Day, Year): January 10, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert M. Dean, M.D. 8901 Wisconsin Ave., Bldg. 8, 3rd Fl., Bethesda, MD 20889

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLOTTE ROSELL WARDENFELT
2. Date of Death: Month January, Day 12, Year 2001
3. Time of Death: 7:51 P.M.
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-54-6621
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 7, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2626 Gilbert Road
10f. Zip Code: 21771
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jacob H. Kaufman
18. Mother's Name (First, Middle, Maiden Surname): Daisy I. Hewitt

19a. Informant's Name/Relationship (Type, Print): Sonja Skuhr / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2626 Gilbert Road Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glade Cemetery
Date: Jan 16 2001
20c. Location - City or Town, State: Walkersville, Maryland

21. Signature of Funeral Service Licensee: ▶ Paul B. MacKay
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Lung Disease — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Philip Konits
29c. License number: D24321
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Philip Konits 2059 Baltimore Blvd Finksburg, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02041

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rachel Christina Weikert

2. Date of Death Month / Day / Year: JANUARY 13 2001

3. Time of Death: 1215 PM

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: None

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: Yrs.

If Under 1 Year: Months / Days: 9

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 4, 2001

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18723 White Sands Drive

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: Mark D. Weikert

18. Mother's Name *(First, Middle, Maiden Surname)*: Michele L. Fawcett

19a. Informant's Name/Relationship *(Type, Print)*: Mark D. Weikert, Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18723 White Sands Dr., Germantown, MD 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Norbeck Memorial Park

Date: Jan 16, 2001

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Barry M. Fenn

22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE SEPSIS — 3 days

Due to (or as a consequence of):

b. EXTREME PREMATURITY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Sukumar MD

29c. License number: 53354

29d. Date signed *(Month, Day, Year)*: January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr M. SUKUMAR MD DIVISION OF NEONATOLOGY 9901 Medical Center Drive ROCKVILLE MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02042

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Samuel William Wilkins
2. Data of Death Month / Day / Year: January 14, 2001
3. Time of Death: 8:20 PM
4a. Facility Name *(If not institution, give street and number)*: 728 Washington Street
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-07-9459
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: January 19, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 728 Washington Street
10f. Zip Coda: 21613
10g. Citizan of What Country?: USA

11. Meritef Status: 1 [ ] Never Merried 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Retired Police Sargeant
16b. Kind of Businass/Industry: Public Service

17. Father's Nama *(First, Middla, Last)*: James Wilkins
18. Mothar's Nama *(First, Middla, Maidan Surname)*: Annie Woolford

19a. Informant's Name/Raletionship *(Type, Print)*: Peggy A. Farrow
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 728 Washington Street Cambridge, Maryland 21613

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, cremetory or other placa)*: Maryland Veterans Cemetary — Data: 01/18/01
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funaral Service Licensee: ▶ Robert L. Boardley
22. Nama and Address of Facility: Boardley Funeral Home 812 Hubbard Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part1. Entar tha disaese, or complicetions that caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on eech line. — Approximata Intarval Batween Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Metastatic Prostate Carcinoma — 2years

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Dua to (or as a consequanca of):
c.
Dua to (or as e consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: Type II Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [X] No

25. Was case referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, date and placa, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: ▶ Eugene J. Newmier DO
29c. Licansa number: H51793
29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Eugene Newmier D.O. 503 Byrn St Cambridge MD 21613

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Julia Zimmerman
01-0185-033
CPS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 23a & 27 per ME G793 032801 SS

Certificate of Death

Reg. No. 2001 02043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Julia	Zimmerman	January 6, 2001	17:05

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	LAUREL	PRINCE GEORGE's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
325-14-1014	1☐ M 2☒ F	80 Yrs.			July 14, 1920	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Beltsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4510 Hartford Avenue	20705	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forcas?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Giva Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		Cashier	Retail

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)
Arzo	Silvey	Katherine L. Gillenburg

19a. Informent's Neme/Reletionship (Type, Print)	19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Joyce Dyer/Daughter	4510 Hartford Ave., Beltsville, MD 20705

20a. Method of Disposition	20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)	Chesapeake Crematory Inc	Jan 15 2001	Beltsville, MD

21. Signature of Funeral Service Licensee: Beverly K. Helmtte

22. Nema end Addrass of Facility: Rapp Funeral & Cremation Services
Stephen D. Lohrmann, 933 Gist Ave.
Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete Intervel Between Onset and Death
Immediete Cause (Final disease or condition resulting in deeth)	a. ~~Pending~~ HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Phyaician**: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
[signature] M.D.	OCME	January 12, 2001

30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
JAN 17 2001	Deputy ▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0411-510
CJ
Gerald Adcock

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERALD M. ADCOCK
2. Date of Death: Month January Day 25 Year 2001
3. Time of Death: 05:55 A.M.
4a. Facility Name (If not institution, give street and number): 5805 Lillyan Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 221-22-3292
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16 1935
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5805 Lillyan Ave. Apt. C-2
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Mechanic
16b. Kind of Business/Industry: Netzer Metal Craft Inc.

17. Father's Name (First, Middle, Last): Archabold Adcock
18. Mother's Name (First, Middle, Maiden Surname): Viola Leazar

19a. Informant's Name/Relationship (Type, Print): Jeanette H. Adcock (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5805 Lillyan Ave. Apt. C-2, Baltimore, Md. 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Date: 01/29/2001
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: George M. Hampton Jr.
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Inspection 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

57

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02045

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: OLGA GRACE AGNEW

2. Date of Death — Month: January Day: 26, Year: 2001

3. Time of Death: 8:40PM

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-8000

6. Sex: 1☐ M 2☒ F (XX)

7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 14, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No (XX)

10e. Street and Number: 39 Murdock Road

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: (XX) Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes (XX) No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes (XX) No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Communications

17. Father's Name *(First, Middle, Last)*: George Spiro Agnew

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Reese

19a. Informant's Name/Relationship *(Type, Print)*: Edward J. McCall III Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10907 Peale Court Austin Texas 78726

20a. Method of Disposition: 1(XX) Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery

Date: 1/30/01

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakos

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non-Hodgkin's lymphoma — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2(X) No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2(X) No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2(X) No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6(X) Other *(Specify)* Hospice

27. Manner of Death: 1(X) Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1(X) **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed *(Month, Day, Year)*: January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: Jenna G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

8:40 pm. JANUARY 26, 2001 AGNEW, OLGA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02046

James Bates.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES E. BATES SR.
2. Date of Death Month / Day / Year: January 23, 2001
3. Time of Death: 9:35 am
4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-9737
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 24, 1933
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3017 WINDSOR AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Merital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): UNKNOWN — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARETAKER
16b. Kind of Business/Industry: DEPT. OF RECREATION & PARKS

17. Father's Name *(First, Middle, Last)*: TEMPLE BATES
18. Mother's Neme *(First, Middle, Maiden Surneme)*: AMANDA MATTHEWS

19a. Informent's Neme/Reletionship *(Type, Print)*: NUBRA BATES (WIFE)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3017 WINDSOR AVE., BALTIMORE, MD. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: MD. NATIONAL CEMETERY — Dete: 01-29-01
20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funerel Service Licensee: C. D. Brown
22. Neme end Address of Feciliy: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory erest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Deeth
Immedieta Cause (Finel diseese or condition resulting in deeth) a.	Sepsis	13 days
Due to (or es a consequence of): b.	Acute Respiratory Failure	4 hours
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last — Due to (or es a consequence of): c.	Acute Renal Failure	3 days
Due to (or es a consequence of): d.	Cerebral Vascular Accident	18 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Meningitis, Pancytopenia, Diabetes
Ischemic Heart Disease
Hepatic Insufficiency, Hepatic Encephalopathy

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner steted.
29b. Signature and title of certifier
29c. License number: D22031
29d. Date signed *(Month, Day, Year)*: 1/29/01
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): LARRY PERRY, M.D. C/O Maryland General Hospital

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 29 2001
32. Registrer's Signeture: Geneva D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0406-005

PEGGY BALWIN

amend item 23a,27 per me G792 2/5/01yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
PEGGY GRANT BALDWIN	JANUARY 24, 2001	10:50A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL	ESSEX	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-70-8789	1☐ M 2☒ F	45 Yrs.			Oct. 13, 1955	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Joppa	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2608 Old Joppa Road	21085	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Office Manager	Law Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harold Ray Spicer	Bernice Virginia Grant

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia G. Spicer - Mother	543 Trimble Road, Joppa, Maryland 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt. Christian Cemetery	1/27/01	Joppa, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen A Hughes	McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA IN ASSOCIATION WITH AORTIC DISSECTION AND CARDIAC HYPERTROPHY	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J Pestaner, MD	O.C.M.E.	JANUARY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 29 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02048

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **Beatrice Ann Bentley**

2. Data of Death Month Day Year: Jan 24, 2001

3. Time of Death: 3:00 a.m.

4a. Facility Name *(If not institution, give street and number)*: 13501 Golden Corn Drive

4b. City, Town, or Location of Death: Highland

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-26-7793

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov 15, 1930

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8720 Ridge Rd. Apt 406

10f. Zip Code: 21043

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: William James Mylin

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Regina Meyer

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Paul Bentley

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9502 Ridgely Ave Baltimore, MD 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All County Cremation Services, Inc.

Date: 01/25/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D18459

29d. Date signed *(Month, Day, Year)*: Jan 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Schaefer, Edward W., MD Howard County Hospital Columbia, Md 21044

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lawrence Brandau
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 9:05 am
4e. Facility Name (If not institution, give street and number): 1851 Marshall Rd.
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-40-4655
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 26, 1944
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1851 Marshall Rd
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Meritel Stefus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman
16b. Kind of Business/Industry: Shipping

17. Father's Neme (First, Middle, Last): John Brandau
18. Mother's Name (First, Middle, Maiden Surname): Florence A. Brecker

19a. Informant's Name/Relationship (Type, Print): Karen Brandau wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1851 Marshall Rd. Dundalk, Md. 21222

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemetery | Date: Jan 27 2001
20c. Location - City or Town, State: Dundalk, Md.

21. Signetura of Funeral Service Licensee: Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. Use only ona cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LIVER FAILURE

Due to (or as a consequence of): ADVANCED LIVER CIRRHOSIS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, end dua to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: A.C. Connelly, MD.
29c. License number: D16306
29d. Date signed (Month, Day, Year): 1/25/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 9125 BELAIR RD BALTIMORE, MD 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signeture: Barbara G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02050

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Bilovesky

2. Date of Death Month / Day / Year: January 25, 2001

3. Time of Death: 5:30 PM

4a. Facility Name *(If not institution, give street and number)*: 1014 Meadow Glen Road

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 183 05 6833

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 19, 1917

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Baltimore | 10c. City, Town or Location: Middle River | 10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street and Number: 1014 Meadow Glen Road | 10f. Zip Code: 21220 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steel Worker

16b. Kind of Business/Industry: Bethlehem Steel Co.

17. Father's Name *(First, Middle, Last)*: John Bilovesky

18. Mother's Name *(First, Middle, Maiden Surname)*: Anne Gaydon

19a. Informant's Name/Relationship *(Type, Print)*: Miriam Phelps (niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1014 Meadow Glen Road Baltimore, Maryland 21221

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Crematory | Date: 1/27/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cardiopulmonary Vascular Accident

Due to (or as a consequence of): b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death:

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury: M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Wallace

29c. License number: 026835

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Valle 1576 Merritt Blvd Balto. 21222

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: [signature] G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold Calvin Braecklein
2. Date of Death: Month 01 Day 24 Year 2001
3. Time of Death: 11:15 am
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-03-3792
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/23/1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10606 Partridge Lane apt. B-3
10f. Zip Code: 21030
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Government Inspector
16b. Kind of Business/Industry: Defense Industry

17. Father's Name (First, Middle, Last): Antone Braecklein
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Lippy

19a. Informant's Name/Relationship (Type, Print): Roberta F. Braecklein / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10606 Partridge Lane apt. B-3; Cockeysville, MD 21030

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Dulaney Valley Memorial Gardens — Date: 1/27/01
20c. Location - City or Town, State: TImonium , MD

21. Signature of Funeral Service Licensee: Peter V. Ruck
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, MD 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Heart Disease
Due to (or as a consequence of):
b. Alzheimers
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph A. Baldanza, MD
29c. License number: D19166
29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph A. Baldanza, MD 10629 York Road; Cockeysville, MD 21030

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02052

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Ennels Butler
2. Date of Death: Month January Day 21 Year 2001
3. Time of Death: 9 30 AM
4a. Facility Name (If not institution, give street and number): Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A
5. Social Security Number: 220-32-9783
6. Sex: 1 ☐ M 2 ☑ F
7. Age (in yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 6, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 3213 Westwood Ave.
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dietitian
16b. Kind of Business/Industry: Hospital
17. Father's Name (First, Middle, Last): Robert Elliott
18. Mother's Name (First, Middle, Maiden Surname): Stella McCready
19a. Informant's Name/Relationship (Type, Print): Tamera Butler
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2920 Baker St. Balt, MD. 21216
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial
Date: 1/27/01
20c. Location - City or Town, State: Randallstown MD.
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Reddington Pass Balt. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. severe pulmonary hypertension — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: pancytopenia, respiratory failure, acute renal failure, congestive heart failure, breast carcinoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D37790
29d. Date signed (Month, Day, Year): January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nevin W Tadd 301 St Paul Place Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: ▶ [signature]

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myron E. Bert

2. Date of Death (Month, Day, Year): JANUARY 25, 2001

3. Time of Death: 947 AM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice @ Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-62-3053

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-01-55

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1806 East 31st. Street

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No XX If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No XX Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintance

16b. Kind of Business/Industry: Johns Hopkins Hosp.

17. Father's Name (First, Middle, Last): Tom Bert

18. Mother's Name (First, Middle, Maiden Surname): Marion Manley

19a. Informant's Name/Relationship (Type, Print): Jacqueline Bert

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4429 Harcourt Road Baltimore, Maryland 21214

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Holly Hills Cemetery

Date: 02-02-2001

20c. Location - City or Town, State: Essex, MD.

21. Signature of Funeral Service Licensee: ▶ Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202

WM.C. March FH 1101 E.North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Human Immuno Defiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medicel examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) STELLA MARIS AT MERCY Hospice

27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D40854

29d. Date signed (Month, Day, Year): JANUARY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02054

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CEDRIC C. CLAYBORNE

2. Data of Death (Month, Day, Year): JANUARY 26 2001

3. Time of Death: 5:25 AM

4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNKNOWN

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 21, 1951

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 28 NORTH BERNICE AVE.

10f. Zip Code: 21229

10g. Citizen of What Country?: USA.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12) / Collega (1-4or 5+): 2YRS

16a. Decedent's Usuai Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: POST OFFICE

17. Father's Neme *(First, Middle, Last)*: LEON CLAYBORNE

18. Mother's Neme *(First, Middle, Maiden Sumame)*: CLAUDIA MAE SCOTT

19a. Intormant's Name/Relationship *(Type, Print)*: LEON CLAYBORNE (FATHER)

19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 28 NORTH BERNICE AVE., BALTIMORE, MD. 21229

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: MT. ZION CEMETERY

Date: 01-31-01

20c. Location - City or Town, Stete: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the daath. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart tailure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Causa (Final diseesa or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentiielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted evants resulting in death) Last

b. Endocarditis

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Respiratory failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part t.: LIVER Failure

23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 X No

24b. Were autopsy tindings available prior to completion of causa of death? 1 ☐ Yes 2 X No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 X No

26. Piece of Death *(Check only ona)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Terance L. Lamb MD

29c. License number: D37203

29d. Data signed *(Month, Day, Year)*: January 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TERANCE L. LAMB MD BON SECOURS Hospital Balt. MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02055

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sharon H. Conroy
2. Date of Death Month Day Year: January 25, 2001
3. Time of Death: 9:45 P.M.
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hosptial
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-56-3578
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10/6/1949
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12006 Amblewood Drive
10f. Zip Code: 20708
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Chinese

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Scientist
16b. Kind of Business/Industry: Computer

17. Father's Name *(First, Middle, Last)*: Bing W. Hum
18. Mother's Name *(First, Middle, Maiden Surname)*: Jean Pong

19a. Informant's Name/Relationship *(Type, Print)*: John Conroy
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12006 Amblewood Drive Laurel, MD 20708

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Baltimore/Washington — Date: 1/31 2001
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Bernard Schneider
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatitis — 2 Months
Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of Certifier: Mark S Rosen D
29c. License number: D20400
29d. Date signed *(Month, Day, Year)*: 1/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Rosen, MD Silver Spring, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GARY P CAMPBELL
2. Date of Death: Month JAN Day 26 Year 2001
3. Time of Death: 820 PM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 217-92-4421
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 36 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15,1964
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD..
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9832 Rainleaf Court
10f. Zip Code: 21045
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef
16b. Kind of Business/Industry: Resturant

17. Father's Name (First, Middle, Last): Harold Campbell
18. Mother's Name (First, Middle, Maiden Surname): Barbara Chapin

19a. Informant's Name/Relationship (Type, Print): Sandra Campbell- wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9832 RAinleaf Court, Columbia, Maryland 21045

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Columbia Memorial Park — Date: 01/29/2001
20c. Location - City or Town, State: Clarksville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Witzke Funeral Home, Inc. 1639 Edmondson Avenue, Catonsville, Maryland21228

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PULMONARY EMBOLISM — 3 DAYS

Due to (or as a consequence of):
b. ASTROCYTOMA OF THE BRAIN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D39629
29d. Data signed (Month, Day, Year): JAN 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. SYMD 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY DEWS
2. Date of Death (Month, Day, Year): JAN. 25 2001
3. Time of Death: 10:10AM
4a. Facility Name (If not institution, give street and number): JOSEPH RICHEY HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-52-7315
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 27, 1944
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residance of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Insida City Limits: 1☒Yas 2☐No
10e. Street and Number: 1802 WEST SARATOGA STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yes 2☒No If Yes, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM BURLEY
18. Mother's Neme (First, Middle, Maiden Surname): VIOLA JEFFERSON

19a. Informant's Name/Relationship (Type, Print): KEVIN BURLEY SR. (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1123 DEANWOOD RD., BALTIMORE, MD. 21234

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): KING MEMORIAL PARK
Date: 01-30-01
20c. Location - City or Town, State: WOODLAWN MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Daath

Immediate Cause (Final disease or condition resulting in death): a. Adenocarcinoma in neck — 1 mo
Due to (or as a consequenca of): Unknown origin

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contributa to the causes of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No
24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No
26. Place of Deeth (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 6☒Other (Specify) Hospice

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: John W. Payne MD
29c. License number: D1312
29d. Date signed (Month, Day, Year): 25 Jan 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne 6565 N. Charles St. 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature] S Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

9:55 AM 1/25/2001 DOROTHY DEWS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice E. DeCarolis
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 1:10 AM
4a. Facility Name (If not institution, give street and number): 7508 Belmont Avenue
4b. City, Town, or Location of Death: Berkshire
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-20-7836
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 9, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Berkshire
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7508 Belmont Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Gegner
18. Mother's Name (First, Middle, Maiden Surname): Lily Stallings

19a. Informent's Name/Relationship (Type, Print): Mr. John A. DeCarolis (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7508 Belmont Ave. Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 1/29/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	minutes
Due to (or as a consequence of): b.	Coronary artery disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Chronic renal failure
Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gwen Oldenquist MD
29c. License number: D0056056
29d. Date signed (Month, Day, Year): Jan. 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gwen Oldenquist MD; JHGC Housecall Program; 5505 Hopkins Bayview Circle; Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: James B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02059

DUKE, NETTIE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nettie C Duke
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 4:55pm
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-34-5519
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 1, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P.O. Box 96
10f. Zip Code: 21009
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 th Grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Ford J. Stone
18. Mother's Name (First, Middle, Maiden Surname): Mary C. Goodman
19a. Informant's Name/Relationship (Type, Print): Charles V. Duke/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 747 Abingdon, Maryland 21009
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park
Date: 1/31/01
20c. Location - City or Town, State: Elkridge, Maryland
21. Signature of Funeral Service Licensee: Christina L. Hilton — ▶ Christina L. Hilton
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Respiraly failure
Due to (or as a consequence of):
b. Sepsis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Perforated Sigmoid Diverticulitis
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Uber House-Staff
29c. License number: D76684
29d. Date signed (Month, Day, Year): 1/27/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kuldip Singh Uber @ Same 6701 North Charles Street, Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT N. ECKSTORM, SR.

2. Date of Death (Month, Day, Year): JAN 22, 2001

3. Time of Death: 1015

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219.16.9127

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 7, 1925

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 143 LOUISE TERRACE

10f. Zip Code: 21061

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NA

16b. Kind of Business/Industry: NA

17. Father's Name (First, Middle, Last): GEORGE W. ECKSTORM

18. Mother's Name (First, Middle, Maiden Surname): Ruth Smith

19a. Informant's Name/Relationship (Type, Print): SHARON K ECKSTORM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 143 LOUISE TERRACE GLEN BURNIE MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN CEM

Date: 1.25.01

20c. Location - City or Town, State: GLEN BURNIE MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: FINK FUNERAL HOME P.A. 436 CRAIN HWY S. GLEN BURNIE MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Sequentially list conditions, if any, leading to immadieta cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. METASTATIC LUNG CANCER

Due to (or as a consequence of):
d. Dehydration

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D43977

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 301 Hospital DRIVE, GLEN BURNIE, MD. 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE C FARMER SR.
2. Date of Death Month: JANUARY Day: 26 Year: 2001
3. Time of Death: 12:30 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 231-18-5351
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 07 1924
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 627 Annabelle Ave.
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinst
16b. Kind of Business/Industry: U.S.Coast Guard

17. Father's Name (First, Middle, Last): George C. Farmer
18. Mother's Name (First, Middle, Maiden Surname): Marie Simpkins

19a. Informant's Name/Relationship (Type, Print): Irene M. Farmer (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 627 Annabelle Ave. Baltimore, Md. 21225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 01/30/2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RIGHT THALAMIC BLEEDING	2 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	ACUTE MYELOGENOUS LEUKEMIA	1 WEEK
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE MYOCARDIAL INFARCTION

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Farah, MD PGY-2 RESIDENT
29c. License number: P 13471
29d. Date signed (Month, Day, Year): JANUARY 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARINA FARAH, MD 3001 S. HANOVER STREET, BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature]

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ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

20+1

ADH
UNKNOWN 01-0337-510
01-016

Bruce Martin Guy

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #23a,27,&28a-f per ME G792-020861-SS

Certificate of Death

Reg. No. 2001 02062

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bruce Martin Guy

2. Date of Death Month Day Year: JANUARY 20, 2001

3. Time of Death: 1800 PM

4a Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: ----------

Funeral Director

5. Social Security Number: 218-72-7581

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 40 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 23, 1960

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 919 Felicia Court

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Reca - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Meat Cutter

16b. Kind of Business/Industry: Retail Grocery Store

17. Fathar's Nama *(First, Middle, Last)*: Bruce Carter Guy

18. Mothar's Neme *(First, Middle, Maiden Surname)*: Jane Patricia Hatfield

19a. Informant's Name/Relationship *(Type, Print)*: Jane P. Guy / Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 919 Felicia Court, Bel Air, Maryland 21014

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Data: 1/26/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funaral Service Licensee: Billy McComas Pennington

22. Nama and Addrass of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final diseesa or condition resulting in death)

a. NARCOTIC INTOXICATION

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disease or Injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Due lo (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yas 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examinar? 1☒ Yas 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Homa 5☐ Residence 8☐ Othar *(Specify)*

27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☒ Could not be determined

28a. Dete of Injury *(Month, Day Year)*: found: 1-20-01

28b. Tima of Injury: found: 5:20 p

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*: found: front porch

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4907 Harford Rd Baltimore, MD

29a. Cartifiar *(Check only one)* 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and placa, and dua to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, dete end place, and dua to tha cause(s) end mannar steted.

29b. Signatura end titla of certifiar: Marguerite Merkell MD

29c. License number: OCME

29d. Data signed *(Month, Day, Year)*: JANUARY 21, 2001

30. Neme and address of parson who completed causa of death (Item 23a) (Type, Print): Margaret D. Koros 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Deta filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Giles Garton

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 7 AM

4a. Facility Name (If not institution, give street and number): Levindale Hebrew Geriatric Center & Hospital

4b. City, Town, or Location of Death: Pimlico

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 218-09-1213

6. Sex: XX M 2☐ F

7. Age (in yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 6, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Colgate

10d. Inside City Limits: 1☐ Yes 2 XX No

10e. Street and Number: 7931 Lansdale Road

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3 XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2 XX No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2 XX No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Food Products

17. Fether's Neme (First, Middle, Last): William G. Garton Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Bertha Schueter

19e. Informent's Neme/Relationship (Type, Print): Robert C. Weatherbee-Step Son

19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7931 Lansdale Rd., Baltimore, Maryland 21224

20e. Method of Disposition: 1☐ Burial 2 XX Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Green Mount Cemetery | Date: 1/26/01

20c. Location - City or Town, Stete: Balto. City, Maryland

21. Signature of Funeral Service Licensee: [signature] M00694

22. Name end Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. | Approximete Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)
a. Pneumonia

Due to (or as a consequence of):
b. Incarcerated Hernia

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Cerebrovascular Accidents
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3 X Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2 X No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2 X No

26. Plece of Deeth (Check only one): Hospitel: 1 X Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1 X Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D23767

29d. Dete signed (Month, Day, Year): January 24, 01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Debra S Wertheimer 2434 W. Belvedere Ave, Balto, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

GARTON, William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Thomas Grade	1 / 25 / 2001	6:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Blue Point N/H	Baltimore	NA

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
225-32-5981	1 X M 2 F	72 Yrs.			12-01-28	VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1028 Woodson Road	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates: X	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th Grade	NA	Forklift operator	Bethlehem Steel Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Grade	Annie Berry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Clayta Grade	1028 Woodson Road Baltimore, Maryland 21212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Morning Star Bapt. Ch. Cem.	01-30-01	Burkeville VA

21. Signature of Funeral Service Licensee ▶ Francis Grace

22. Name and Address of Facility Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Cardiopulmonary failure	1 wk
Due to (or as a consequence of):	b. Chronic Renal Failure	~10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Arteriosclerosis	~20 yrs.
Due to (or as e consequence of):	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial infarction
Cerebrovascular Disease
Alzheimer's Dementia

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 X Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	MD7494	1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 Cross Road Drive 21117
Dr. Monique Landston, MD Medical Specialist Building Owings Mills, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 29 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-0401-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

CYNTHIA GRACEY AMENDED ITEMS #23, 27, 28a-f per M.E. G792 020101 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Cynthia	Gracey	JANUARY 24, 2001	4:08P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-84-0374	1☐M 2☒F	39 Yrs.			Dec 15, 1961	Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2110 Merritt Blvd	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yas 2☒No If Yes, Give Yaar or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.		Never Worked	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gary N. Gracey Sr.	Sally A. Maguire

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gary N. Gracey Sr. Father	2110 Merritt Blvd. Dundalk, Md. 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory	Jan 28 2001	Baltimore City

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND ALCOHOL INTOXICATION
Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yas 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	FOUND 1/24/01	UNKNOWN M	1☐Yes 2☒No	UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND AT HOME	7007 DUNMANWAY, DUNDALK, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Pestaner, M.D	O.C.M.E.	JANUARY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 29 2001	▶

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02066

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)		2. Dete of Death Month / Dey / Yeer	3. Time of Death
SARA	GLAZER	JANUARY 25, 2001	3:00 AM

4e Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LEVINDALE HEBREW HOME	BALTIMORE	N/A

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthpleca (State or Foreign Country)
220-14-3908	1☐ M 2☒ F	91 Yrs.			DEC. 25, 1909	RUSSIA

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3800 OLD COURT ROAD	21208	U.S.A.

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	2	HOMEMAKER	OWN HOME

17. Fether's Name (First, Middle, Last)		18. Mother's Neme (First, Middle, Maiden Surneme)	
HARRY	FOX	BECKIE	NUDELMAN

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
LOWELL GLAZER / SON	4001 OLD COURT ROAD #300 - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	BETH TFILOH CONGREGATION	1/26/01	WOODLAWN, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler

22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immedtete Cause (Final diseese or condition resulting in deeth)	e. Consestive Heart Failure	year
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leeding to immedicte ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest	b. Severe Aortic Stenosis	year
	Due to (or as e consequence of):	
	c.	
	Due to (or es e consequenca of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I. Dementia, Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medicel examiner?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medicel Examiner:** On the basis of exemineticn end/or investigation, in my opinion, deeth occurred at the time, dete end place, snd due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Yeer)
John M. Lyons	D33943	1/25/2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Susan N. Levy MD Levindale

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
JAN 29 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD
01-0386-510
ROSE
GREENWALD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED# 23,ptII, 27,28a-f per ME G793 032001 SS

Reg. No. 2001 02067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
ROSE	GREENWALD	JANUARY	23,	2001	8:29P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-48-0984	1☐ M 2☒ F	81 Yrs.			NOV.25,1919	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2318 SMITH AVENUE	21209	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN ASNER	MOLLIE WEINBERG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GARY GREENWALD / SON	4305 CRESTHEIGHTS ROAD - BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MOSES MONTEFIORE WOODMOOR	1/26/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Scott M. Cuttler	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COMPLICATIONS OF A PERFORATED COLONIC DIVERTICULUM ASSOCIATED WITH COLONOSCOPY	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LYMPHOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day, Year)	26b. Time of Injury	26c. Injury at Work?	26d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	12-9-00	P M	1☐ Yes 2☒ No	colon perforated associated with colonoscopy

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
hospital	Sinai Hospital Greenspring & Coldspring Lns,Balto, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	O.C.M.E.	JANUARY 24,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kristy G. Rollock M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 29 2001	▶ Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02068

Harrod Irene

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IRENE HARROD
2. Date of Death — Month: January Day: 26th Year: 2001
3. Time of Death: 1:40PM
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel.

Funeral Director

5. Social Security Number: 218-36-2283
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 03-25-1939
9. Birthplace *(State or Foreign Country)*: MD

Usual Residance of Decedant

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 721 CHAPEL GATE DR.
10f. Zip Coda: 21133
10g. Citizen of What Country?: USA

11. Marital Stafus: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Waa Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* BLACK

15. Decedent'a Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: NURSING
16b. Kind of Businass/Industry: SELF EMPLOYED

17. Fathar's Nama *(First, Middla, Last)*: RAY ROBINSON
18. Mothar's Nama *(First, Middla, Maiden Surnama)*: DOROTHY HARROD

19a. Informant's Name/Ralationship *(Type, Print)*: GAIL TRIPLIN, DAUGHTER
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7906 DUNHILL VILLIAGE CIR, 302 BALTO. 21244

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: MOUNT ZION CEMETERY — Data: 2-2-01
20c. Location - City or Town, Stata: BALTIMORE

21. Signature of Funaral Service Licensee: Willie E. Howell Jr.
22. Nama and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, ahock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. Possible Cerebrovascular Accident-
Dua to (or as a consequence of):
b. Hypertensive Athrosclerotic disease.

Sequantially list conditions, If any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated evants resulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.
Deabeles Mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to madical axaminar? 1☐ Yas 2☒ No
26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: ☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.
29b. Signatura and title of certifier: [signature]
29c. Licansa number: D51596
29d. Data signed *(Month, Day, Year)*: January 26th 2001
30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): K-Ambalavanar 716 Maiden Choice Lane, Catonsville MD 21228

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signatura: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02069

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH EDWARD HAARER

2. Date of Death — Month: JAN Day: 20 Year: 2001

3. Time of Death: 3:10pm

4a. Facility Name *(If not institution, give street and number)*: 7250 Lasting Light Way

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 338-22-3773

6. Sex: 1☐ M X 2☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Jan 11, 1929

9. Birthplace *(State or Foreign Country)*: Illinois

Usuet Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☐ X No

10e. Street and Number: 7250 Lasting Light Way

10f. Zip Code: 21045

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☐ X Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ X Yes 2☐ No If Yes, Give Yeer or Dates: 1948 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ X No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Data Processsing Manager

16b. Kind of Business/Industry: Smelkin Brothers (Sysco)

17. Father's Neme *(First, Middle, Last)*: August Haarer

18. Mother's Name *(First, Middle, Maiden Surneme)*: Freda Miller

19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Elida L. Haarer

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7250 Lasting Light Way Columbia, Maryland 21045

20a. Method of Disposition: 1☐ X Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Crest Lawn Memorial Gardens

Dete: 01/24/01

20c. Location - City or Town, Stete: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: M00538

22. Name end Address of Fecility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complieations that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. UROSEPSIS

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Colon cancer, Shy-DRAGER syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ X Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ X No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ X No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ X Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☐ X Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☐ X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: M BOURSIQUOT MD

29c. License number: D0057958

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and eddess of person who completed cause of death (Item 23a) (Type, Print): M BOURSIQUOT MD TWO CHOY NORTH DRIVE COLUMBIA MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signeture: Jeanne B Scott

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02070

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward E Hardway

2. Date of Death (Month, Day, Year): Jan 26 2001

3. Time of Death: 19:39

4a. Facility Name *(If not institution, give street and number)*: 822 MArtin Road

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234-22-1371

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Sept 12 1920

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Rasidance of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 822 Martin Road

10f. Zip Coda: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 ☒ Yas 2 ☐ No If Yes, Give Yaar or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 2yrs

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Machinest

16b. Kind of Businass/Industry: Middle StatMachineCo.

17. Fathar's Nama *(First, Middle, Last)*: Alvin Hardway

18. Mothar's Nama *(First, Middle, Maiden Surnema)*: Edna Saruer

19a. Informant's Name/Ralationship *(Type, Print)*: Donna Hoag /daughter

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 150 Mountain View Ave. Walkhill , New York 12589

20a. Mathod of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or othar place)*: Metro Crematory Inc. — Data: 1/31/01

20c. Location - City or Town, Stata: Baltimore Maryland

21. Signature of Funaral Sarvice Licensee: R. Terry Connelly

22. Neme and Addrass of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not entar tha moda of dying, such es cardiec or respiratory arrast, shock, or haart feilure. List only ona ceuse on aach lina.

Approximate Intarval Batween Onset and Death

Immediate Causa (Final disaasa or condition resulting in death)
a. Arteriosclerotic Cardiovascular disease — 35yrs

Due to (or as a consequence of):

Sequantially list conditions, if eny, leading to immedieta causa. Entar Underlying Cause (Disaase or injury that initiated events resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Ware autopsy findings available prior to complation of ceuse of death? 1 ☐ Yas 2 ☒ No

25. Was casa referrad to medical examiner? 1 ☒ Yas 2 ☐ No

26. Place of Deeth *(Check only ona)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Homa 5 ☒ Rasidence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledga, daath occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On tha basis of examination and/or invastigetion, in my opinion, daath occurred at the tima, data and piace, and dua to tha ceuse(s) and menner stated.

29b. Signature and title of certifiar: ~~Hetitello~~ MD Deputy

29c. License number: D18667

29d. Data signed *(Month, Day, Year)*: January 27, 2001

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): Philip Militello, M.D. Shock Trauma 22 S. Greene ST. Baltimore, Md 21201

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signatura: Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0432-005

TONI

HAYES AMENDED ITEMS# 23,ptII,&27 per ME G792 022001 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Toni Carolyn Hayes	JANUARY 25, 2001	7:55P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9622 HARDING AVE	PARKVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214 76 5922	1☐M 2☒F	43 Yrs.			Sept.9,1957	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Parkville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9622 Harding Avenue	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anthony Tranguccio	Regina Marie Tootill

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Giles E. Hayes (Husband)	9622 Harding Ave. Baltimore, Md. 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gardens Of Faith Cemetery	1/29/2001	Baltimore, Md.

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
John W. Burkowske	MO1091	Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CIRRHOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC NARCOTISM

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Dennis J Chute MD	O.C.M.E.	JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	Geneva D Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02072

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary A. Jones

2. Date of Death — Month: JANUARY Day: 25 Year: 2001

3. Time of Death: 9:45 A.M.

4a. Facility Name *(If not Institution, give street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 199-22-3604

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Nov. 13, 1927

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 705 Fuselage Avenue

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: seamstress

16b. Kind of Business/Industry: uniform manufacturer

17. Father's Name *(First, Middle, Last)*: John J. Kundrick

18. Mother's Name *(First, Middle, Maiden Surname)*: Veronica Kisela

19a. Informant's Name/Relationship *(Type, Print)*: Monica Hill (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 150 Holly Circle, Baltimore, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens

Date: 1/27/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

JONES, MARY

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. TERMINAL MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: D 203356

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TOWANNA FONTENOT, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): T. J. Johnson
2. Date of Death (Month, Day, Year): Jan. 23, 2001
3. Time of Death: 3:30pm
4a. Facility Name (If not institution, give street and number): Harbor Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 250-20-7345
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-22-22
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1563 Homestead Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer
16b. Kind of Business/Industry: Baltimore City Jail

17. Father's Name (First, Middle, Last): David Johnson
18. Mother's Name (First, Middle, Maiden Surname): Mary Sampson

19a. Informant's Name/Relationship (Type, Print): Colenea Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1563 Homestead Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Nat'l Cem.
Date: 01-31-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Francis M[illegible]
22. Name and Address of Facility: M.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Myocardial infarction — 4 hrs
Due to (or as a consequence of):
Cerebrovascular Accident
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c. Atrial fibrillation
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D30641
29d. Date signed (Month, Day, Year): January 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi 200-109 Back River Neck Rd Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald King

2. Date of Death: Month 1 Day 21 Year 01

3. Time of Death: 12:06am

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore.

4c. County of Death:

Funeral Director

5. Social Security Number: 216-40-2159

6. Sex: 1☒ M 2☐ F

7. Age (If yrs. last birthday): 37 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 10, 1963

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2500 N. Charles Street

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): unk

College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): Stephen N. King

18. Mother's Name (First, Middle, Maiden Surname): Sylvia O. Washington

19a. Informant's Name/Relationship (Type, Print): Md. General Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 827 Linden Avenue Baltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis - Renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Bailey

29c. License number: P14583

29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Baddy Nischal, M.D. Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Ronald King
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #20b per fh G791 012901 SS

Certificate of Death

Reg. No. 2001 02075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Diana Faye Kniffin

2. Date of Death: Month Jan. Day 25 Year 2001

3. Time of Death: 11:55 pm.

4a. Facility Name (If not institution, give street and number): 1015 Nicodemus Rd.

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-44-9847

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 24, 1943

9. Birthplace (State or Foreign Country): W.V.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1015 Nicodemus Rd.

10f. Zip Code: 21136

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Edla Hall

18. Mother's Name (First, Middle, Maiden Surname): Irene Wilbur

19a. Informant's Name/Relationship (Type, Print): James Douglas Kniffin - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1015 Nicodemus Rd. Reisterstown, Md. 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory

Date: Jan. ~~25~~ 26, 2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ J. Keith Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER — 3 YEARS

Due to (or as a consequence of):

b. BREAST CANCER — 7 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. Wolff MD

29c. License number: D39774

29d. Date signed (Month, Day, Year): 01/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTONIO C. WOLFF - The Johns Hopkins Oncology Ctr.

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02076

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA H. LEMLEY

2. Date of Death: Month 1 Day 27 Year 2001

3. Time of Death: 8:40 AM

4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE OF SEVERNA PARK

4b. City, Town, or Location of Death: SEVERNA PARK

4c. County of Death: ANNE ARUNDEL COUNTY

Funeral Director

5. Social Security Number: 175-18-1707

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 19 1921

9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Millersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 604 Milldan Court # 34

10f. Zip Code: 21108

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Lester Lemley Sr.

18. Mother's Name (First, Middle, Maiden Surname): Emma Vance

19a. Interment's Name/Relationship (Type, Print): Shirley J. Young (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 Oak Spring Drive, Glen Burnie, Md. 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 01/30/2001

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: John T. Ellis

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 1 Day

Due to (or as a consequence of):

b. Coronary Artery Disease — 1 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Advanced Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Cyriac MD Attending Doctor

29c. License number: D21684

29d. Date signed (Month, Day, Year): 1-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.V. CYRIAC M.D 8021 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva B. Sanks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donna Eugene Lillibridge
2. Date of Death: Month January, Day 24, Year 2001
3. Time of Death: 7:30 PM
4e. Facility Name (If not institution, give street and number): Good Samaritan Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 104-36-1691
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): January 28, 1928
9. Birthplace (State or Foreign Country): South Dakota

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1601 E. Belvedere Avenue
10f. Zip Code: 21239
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teller
16b. Kind of Business/Industry: Bank

17. Father's Name (First, Middle, Last): Daniel B. Rupchis
18. Mother's Name (First, Middle, Maiden Surname): Ruby Powers

19a. Informant's Name/Relationship (Type, Print): Lyle R. Lillibridge (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 632 Oak Farm Court Timonium, Maryland 21093

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crown Hill Memorial Park
Date: 1/29/01
20c. Location - City or Town, State: Kirkland, New York

21. Signature of Funeral Service Licensee: ▶ Steven T. Zittle
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Atherosclerotic Cardiovascular Disease	10 years
Due to (or as a consequence of):	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Thomas S. Wilson MD
29c. License number: D40277
29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Thomas S. Wilson, M.D. 5601 Loch Raven Blvd. Suite 502 Baltimore, Maryland 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: ▶ Donna G. Yeats

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0397-510
crn
Clifton Moore
Amended Item#20b-c perFHG791 1/29/01 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
CLIFTON	MOORE	January 24, 2001	5:45 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-36-3883	1☒M 2☐F	61 Yrs.			AUG. 28, 1939	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1800 HOLLINS STREET	21223	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		LAB TECHNICIAN	DENTAL GROUP

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM MOORE	FRANCIS SMITH

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BARBARA MARABLE (SISTER)	2865 W. MULBERRY ST, BALTIMORE MD. 21223

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Western Star Cemetery ~~MT. ZION CEMETERY~~	01-29-01	Catonsville ~~LANSDOWNE~~, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death)
a. Pulmonary Thromboembolism

Due to (or as a consequence of):
b. Inferior Vena Cava Thrombosis

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Renal Cell Carcinoma

23b. Did tobacco use contribute to the cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Piece of Injury - At home, farm, streat, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	January 25, 2001

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)
J. LAON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signeture
JAN 29 2001	Jennie B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM # 19b per fh G791 012901 SS

Certificate of Death

Reg. No. 2001 02079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHARON DENISE MOORE

2. Date of Death: Month JANUARY Day 28 Year 2001

3. Time of Death: 6:25AM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 214-84-0359

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 33 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 29, 1967

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: none

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 608 W. Lafayette Ave

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH

College (1-4or 5+): 4th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Clerk

16b. Kind of Business/Industry: Super Fresh store

17. Father's Name (First, Middle, Last): Fred Moore

18. Mother's Name (First, Middle, Maiden Surname): Velma Pino Moore

19a. Informant's Name/Relationship (Type, Print): Velma Moore (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 W. Lafayette Ave Baltimore, Maryland 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Western Star

Date: 1/31/01

20c. Location - City or Town, State: Ingleside, Maryland 21228

21. Signature of Funeral Service Licensee: Nancy M. Lewis

22. Name and Address of Facility: Nancy M. Wallace Funeral Service 3403 W. Franklin St. Baltimore, Md 21209

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PLASMA CELL LEUKEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fernando A. Lopez MD

29c. License number: 60 1296

29d. Date signed (Month, Day, Year): JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FERNANDO A. LOPEZ MD 22 SOUTH GREENE STREET BALTIMORE MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#10e&19b PER F.H. G792 2-2-2001 JAB **Certificate of Death**

Reg. No. 2001 02080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUSSELL THOMAS MACK
2. Data of Death: Month JAN Day 29 Year 2001
3. Time of Death: 8:35 am
4a. Facility Name (If not institution, give street and number): Manor Care - Rossville
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-05-4153
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 24 1921
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: ~~125~~ 725 Middlesex Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yas 2☐No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Substation Operator
16b. Kind of Business/Industry: BaltimoreGas&Electric

17. Father's Nama (First, Middle, Last): Thomas Mack
18. Mother's Nama (First, Middle, Maiden Surnama): Lorraine Spalding

19a. Informant's Name/Relationship (Type, Print): Audrey Mack / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): ~~125~~ 725 Middlesex Road Baltimore MD. 21221

20a. Mathod of Disposition: 1☐Burial 2☒Cremation 3☐Removal Irom State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cematary, crematory or other place): Metro CRematory Inc. | Data: 1/30/01
20c. Location - City or Town, Stata: Baltimore MD.

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Nama and Address of Facility: Connelly Funeral Home of essex 300 MAce AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 10 yrs

Due to (or as a consequence of):
b. CHRONIC LEFT PLEURAL EFFUSION — 1 year

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STROKE, CORONARY ARTERY DISEASE
ATRIAL FIBRILLATION, HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☐No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was casa refarred to medicat examiner? 1☐Yes 2☒No
26. Place of Death (Check only ona): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Homa 5☐Rasidence 6☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, and due to tha cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and titla of certifier: D.O.
29c. License number: H35593
29d. Data signed (Month, Day, Year): JAN. 29,2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. JOHN J. LOH 1124 MACE AVE., BALTO. MD. 21221

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signatura: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1/29/01 8:35 Am

Mack, Russell

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a per PHYG791 1/29/01 EW

Certificate of Death

Reg. No. 2001 02081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Ann Moye

2. Date of Death (Month, Day, Year): January 09 2001

3. Time of Death: 12:16 pm

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Caton Manor

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-30-0389

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/9/29

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 3330 Wilkens Ave.

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Wilbur Kenneth Williams

18. Mother's Name (First, Middle, Maiden Surname): Sarah Hawkins

19a. Informant's Name/Relationship (Type, Print): Karen Smith - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 S. Mount Olivet Ln. Balto, MD. 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk.

Date: 1-13-01

20c. Location - City or Town, State: Arbutus, MD.

21. Signature of Funeral Service Licensee: David Mark

22. Name and Address of Facility: Gary P. March Funeral Home P.A. 240 Frederick Rd Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	recurrent bronchopneumonia	couple days
Due to (or as a consequence of):	TERMINAL PNEUMONIA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	~~recurrent aspirations~~	one month
Due to (or as a consequence of):		
c.	recurrent stroke	one month
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

chronic obstructive lung disease

seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jerry D. Sparks MD

29c. License number: D29767

29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jerry Sparks 8418 Baltimore-Annapolis Blvd. MD Pasadena 21122

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Name: Ruth Moye

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02082

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ponda M. Mack

2. Date of Death — Month: JANUARY Day: 21 Year: 2001

3. Time of Death: 6 55 A

4a. Facility Name (If not institution, give street and number): Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: ink

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 17, 1961

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1613 Mullikin Ct.

10f. Zip Code: 21231

10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): James Walker

18. Mother's Name (First, Middle, Maiden Surname): Shirley Mack

19a. Informant's Name/Relationship (Type, Print): Margaret Owens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8333 Mindale Circle Apt. D. Balto., MD 21244

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk.

Date: 1/25/01

20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: Carol Mack

22. Name and Address of Facility: Carol E. Mack Funeral Home P.A. 5410 Fredrick Ave Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MOLISSA NASH

2. Date of Death: Month: January Day: 25 Year: 2001

3. Time of Death: 9:15am

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital 5601 Loch Raven Blvd

4b. City, Town, or Location of Death: Baltimore MD 21239 Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 230-22-3109

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-28-17

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1909 Eloise Lane

10f. Zip Code: 21040

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lunch Aide

16b. Kind of Business/Industry: School System

17. Father's Name (First, Middle, Last): Jerry Mosby

18. Mother's Name (First, Middle, Maiden Surname): Ella Mae Tanner

19a. Informant's Name/Relationship (Type, Print): Rev. Dr. Jerry Mosby

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2070 Seward Avenue Apt."K" Bronx, N.Y. 10466

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery Date: 02-03-01

20c. Location - City or Town, State: Bronx, N.Y.

21. Signature of Funeral Service Licensee: Joseph R. Walters Jr

22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P14421

29d. Date signed (Month, Day, Year): January/25/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Maryan Zamanian, MD Good Samaritan Hosp., 5601 Loch Raven Blvd, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02084

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): VERNON PEELE

2. Date of Death Month Day Year: January 25, 2001

3. Time of Death: 0152

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

5. Social Security Number: 213-16-6661

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 13, 1922

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 101 LONG PINE PLACE, APT #1A

10f. Zip Code: 21244

10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: BREWERY

17. Father's Name (First, Middle, Last): JAS PEELE

18. Mother's Name (First, Middle, Maiden Surname): BLANNIE EVERETT

19a. Informant's Name/Relationship (Type, Print): VIVER CUNNINGHAM (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2009 N. MONROE ST, BALTIMORE, MD, 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): DRUID RIDGE CEMETERY Date: 02-01-01

20c. Location - City or Town, State: PIKESVILLE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

To Be Completed by Funeral Director

Patient known as: Vernon D Peele

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. GI Bleed — 2 weeks

Due to (or as a consequence of):
b. Myocardial Infarction — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Sepsis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29b. Signature and title of certifier: Edward Obazee MD

29c. Licensa number: D41430

29d. Date signed (Month, Day, Year): JAN 25 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. EDWARD OBAZEE 5309 A OLD COURT RD. RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha R. Presbury
2. Date of Death: Month JANUARY Day 24, Year 2001
3. Time of Death: 20:56
4a. Facility Name (If not institution, give street and number): St. Agnes Hosp.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-80-1010
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-29-1913
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 1525 Lester Court - Apt 4
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Private Duty

17. Father's Name (First, Middle, Last): Johnny Barnes
18. Mother's Name (First, Middle, Maiden Surname): Mary Barnes

19a. Informant's Name/Relationship (Type, Print): Doretha Clark / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1525 Lester Court - Apt. 4, Balt., MD 21205

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 1/31/2001
20c. Location - City or Town, State: Lanse Corune MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hari P. Close Funeral Service, P.A. 709 Tessier St. Balt. MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Coronary Artery Disease
Diabetes Mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edana Mann, M.D.
29c. License number: D0056092
29d. Date signed (Month, Day, Year): January 24, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edanamann 900 Caton Avenue Baltimore, maryland 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PRESBURY, BERTHA
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02086

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas A. Przywara

2. Date of Death — Month: January Day: 29 Year: 2001

3. Time of Death: 6:45 am

4a. Facility Name *(If not institution, give street and number)*: 332 Maple Avenue

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-01-9065

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Feb. 16, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 332 Maple Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Alban Tractor Co.

17. Father's Name *(First, Middle, Last)*: Thomas J. Przywara

18. Mother's Name *(First, Middle, Maiden Surname)*: Sophia Holewinski

19a. Informant's Name/Relationship *(Type, Print)*: Genevieve Przywara (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 332 Maple Avenue, Essex, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart of Jesus

Date: 1/31/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Esophageal Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Paul Valle MD

29c. License number: D26835

29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Paul Valle, MD 1576 Merritt Blvd Balto MD 21222

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 10A PER F.H. G791 1-29-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAY E. PETRARCA
2. Date of Death (Month, Day, Year): Jan. 23 2001
3. Time of Death: 14:49
4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: Worchester County

Funeral Director

5. Social Security Number: 216-12-7298
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 31 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: ~~Md.~~ Delaware
10b. County: Sussex County
10c. City, Town or Location: Selbyville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 40 F Laws Point Road Swan Keys
10f. Zip Code: 19975
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife
16b. Kind of Business/Industry: Home Owner

17. Father's Name (First, Middle, Last): Norman Bollinger
18. Mother's Name (First, Middle, Maiden Surname): Pearl L. Harrison

19a. Informant's Name/Relationship (Type, Print): Frederick Petrarca (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19975: 40 F. Laws Point Road, Swan Keys Selbyville Del.

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemt.
Date: 01/26/2001
20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: John F. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. septic shock — 3 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Physician
29c. License number: H44283
29d. Date signed (Month, Day, Year): 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Burke 9733 Heathway Drive Berlin, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Petrarca, May E. 10/31/23 216 12 7298 (S.S.)

1/23/01 1449

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #7 PER F.H. G791 1-29-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES E. PORTER JR.

2. Date of Death Month Day Year: JANUARY 24 2001

3. Time of Death: 1:00 PM

4a. Facility Name (If not institution, give street and number): 5666 ROBERTS COURT

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 212-22-7955

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 74 ~~75~~ Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 21 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5666 Roberts Court

10f. Zip Code: 21061

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unemployed

16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): James E. Porter, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Nagel

19a. Informant's Name/Relationship (Type, Print): Ray R. Porter, Sr. (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 123 West Meadow Road, Brooklyn, Md. 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 01/29/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebro vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Anita Khandelwal MD

29c. License number: D0052490

29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anita Khandelwal MD 3001 S. Hanover St. Baltimore MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eva Schoenhals Placht

2. Date of Death: Month January Day 20, Year 2001

3. Time of Death: 12:03 P.M.

4a. Facility Name (If not institution, give street and number): Roland Park Place

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-76-1709

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 24, 1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 830 W. 40th. Street

10f. Zip Code: 21211

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): George W. Schoenhals

18. Mother's Name (First, Middle, Maiden Surname): Anna Lamley

19a. Informant's Name/Relationship (Type, Print): Anne P. Blum (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Cherry Lane, Shrewsbury, PA 17361

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: 1-23-01

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: John O. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure in assoc. with Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hip Fracture

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 12/26/00

28b. Time of Injury: 3:15 AM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Fell in bathtub

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home - Apartment

28f. Location (Street and Number or Rural Route Number, City or Town, State): 830 W. 40th St Apt 208 Baltimore, MD

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D I Dr

29c. License number: D37133

29d. Data signed (Month, Day, Year): 1/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donna L. Dow MD 7600 Osler Drive #209 Towson, MD 21204

State Registrar

31. Data filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02090

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Milton Joseph Pimental

2. Date of Death (Month, Day, Year): Jan. 24 2001

3. Time of Death: 10:20 pm.

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 026-07-1856

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 25, 1918

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Glyndon

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4126 Worthington Ave.

10f. Zip Code: 21071

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Year of Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Peter Pimental

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Ann

19a. Informant's Name/Relationship *(Type, Print)*: Dora V. Pimental - wife

19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4126 Worthington Ave. Glyndon, Md. 21071

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LakeView Mem. Park

Date: Jan. 27, 2001

20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: J. Hall Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finei diseese or condition resulting in death)

a. Subarachnoid Hemorrhage

Due to (or es e consequence ot):

Sequentially iist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number: D43725

29d. Dete signed *(Month, Day, Year)*: 01/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

January 24, 2001 10:20 p.m.

Milton Pimental

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELTON RICHARDS

2. Data of Death Month Day Year: JANUARY 26, 2001

3. Time of Death: 8 35 AM

4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CTR, (HOSPICE)

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-96-7607

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-16-1942

9. Birthplaca (State or Foreign Country): TRINADAD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 3900 MOUNTWOOD RD

10f. Zip Code: 21219

10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar In U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): CONTRACTOR

16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Neme (First, Middle, Last): CLIFFORD SMALL

18. Mother's Name (First, Middle, Meiden Surneme): HAGAR RICHARDS

19a. Informant's Name/Relationship (Type, Print): SANDRA DESILVER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3900 MOUNTWOOD RD, BALTIMORE, MD 21219

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King MEMORIAL PARK

Date: 1-31-01

20c. Location - City or Town, Stata: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Willie E. Howell Jr

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complications thet caused the daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colorectal Cancer.

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 X Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 X **Certifying Physician**: To the best of my knowledge, death occurred et tha time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: ▶ MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): JANUARY 26, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: ▶ Regina G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02092

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary E. Riddle

2. Date of Death — Month: 01 Day: 17 Year: 2001

3. Time of Death: 12:48 A.M.

4a. Facility Name *(If not institution, give street and number)*: North Hampton Manor

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-20-1270

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jul 16, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4360 Baptist Rd.

10f. Zip Code: 21787-1718

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Lee D. Pomeroy

18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Moxely

19a. Informant's Name/Relationship *(Type, Print)*: Mr. John Lee Riddle

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3590 Round Bottom Rd. Cincinnati, Ohio 45244-3026

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. View Cemetery

Date: 01/19/01

20c. Location - City or Town, State: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

ATRIAL FIBRILLATION

DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D32171

29d. Date signed *(Month, Day, Year)*: 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD L. GOUGH MD 19 W FREDERICK ST WALKERSVILLE MD 21793

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE PETRO ROGGIO

2. Date of Death (Month, Dey, Yeer): January 24, 2001

3. Time of Death: 5:00 PM

4a. Facility Name (If not institution, give street and number): 1624 Providence Rd.

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-36-3652

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 14, 1940

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1624 Providence Rd.

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Telemarket

17. Father's Name (First, Middle, Last): Samuel Roggio

18. Mother's Neme (First, Middle, Maiden Surname): Gertrude Kalinowski

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary J. Roggio/wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1624 Providence Rd. Towson, Md. 21286

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 1/27/01

20c. Location - City or Town, State: Overlea, Md.

21. Signature of Funeral Service Licensee:

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)

a. coronary artery disease — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MI 1993, obesity

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): N/A

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier:

29c. License number: D41104

29d. Date signed (Month, Day, Year): 1.25.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore Houck, MD 7825 York Rd. Towson, Md. 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET RIXHAM
2. Date of Death (Month, Day, Year): JANUARY 25, 2001
3. Time of Death: 4:00PM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-03-3043
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 24, 1912
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Pikesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 407 South Road
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookeeper
16b. Kind of Business/Industry: Sign Company

17. Father's Name (First, Middle, Last): Charles I. Stewart, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Pearl I. Uhler

19a. Informant's Name/Relationship (Type, Print): Charles I. Stewart, Jr. Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Chetwick Court, Owings Mills, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 1/29/01
20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: James B. Eline
22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Road, Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Renal Failure
MI

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D1[illegible]05
29d. Date signed (Month, Day, Year): January 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.J. IMPERIAL, JR. MD — Nwhe.

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #30 PER D.V.R. G791 WR.

Certificate of Death

Reg. No. 2001 02095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL RUBIN
2. Date of Death (Month, Day, Year): JANUARY 25, 2001
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): JEWISH CONVALESCENT CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 143-32-5626
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN.24,1928
9. Birthplace (State or Foreign Country): HUNGARY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7920 SCOTTS LEVEL ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHOPKEEPER
16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): (UNKNOWN) RUBIN
18. Mother's Name (First, Middle, Maiden Surname): (UNKNOWN) (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): MICHAEL HOLLOWAY / ATTORNEY
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 N. CALVERT ST. #620 - BALTIMORE, MD 21202

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY
Date: 1/26/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert [illegible]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METABOLIC IMBALANCE — ±1 MOS
Due to (or as a consequence of):
b. DEHYDRATION
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DIDS
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PARKINSON'S DISEASE
OLD CVA.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Raymond F. Caplan M.D.
29c. License number: D-04601
29d. Date signed (Month, Day, Year): 1/28/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND F. CAPLAN SUITE #300 1838 GREENETREE RD. BALTIMORE MD 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FREDERICK JEROME STEPNEY
01-0458-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02096

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FREDERICK JEROME STEPNEY
2. Date of Death Month Day Year: JAN. 26, 2001
3. Time of Death: 2049 PM
4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 217-02-7844
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 21 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APRIL 7, 1979
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 107 S. CAREY STREET
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 10th
College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: FRED STEPNEY
18. Mother's Name *(First, Middle, Maiden Surname)*: HATTIE ROGERS

19a. Informant's Name/Relationship *(Type, Print)*: HATTIE ROGERS (MOTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 107 S. CAREY STREET BALTIMORE, MD 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: MT. ZION CEMETERY
Date: 2/2/2001
20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound of Back of Right Chest
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☑ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 1-26-01
28b. Time of Injury: 2000 hrs M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject shot
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 107 S. Carey St Baltimore, Md

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] / Chief
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JAN. 28, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

VOID

CERTIFICATE #

01-02097

SEE

CERTIFICATE #

00-43633

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02098

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **Mary Catherine Sauter**

2. Date of Death Month Day Year: January 22, 2001

3. Time of Death: 7:50 pm

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Nursing & Rehab Center

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 219-64-8890

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 10, 1910

9. Birthplace *(State or Foreign Country)*: Ellicott City,

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3311 Rogers Ave

10f. Zip Code: 21043

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Ezekial Robert Moxley

18. Mother's Name *(First, Middle, Maiden Surname)*: Cora Willa Catherine Snyder

19a. Informant's Name/Relationship *(Type, Print)*: Mr. William S. Sauter Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8526 Linwood Dr. Ellicott City, Maryland 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. John's Cemetery

Date: 01/26/2001

20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: [signature] M00385

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — 36 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] James C. Richardson MD

29c. License number: D27394

29d. Date signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richardson, James P., M.D. 700 Geipe Road Catonsville, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02099

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **Elizabeth H. Sperling**

2. Date of Death (Month, Day, Year): Jan 24, 2001

3. Time of Death: 8:15 AM

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Hospice Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-50-3391

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sep 4, 1955

9. Birthplace *(State or Foreign Country)*: Washington D.C

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10623 Millet Seed Hill

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Software Consultant

16b. Kind of Businass/Industry: Digital Equipment

17. Fathar's Nama *(First, Middla, Last)*: Newton E. Hill

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Binkley

19a. Intorment's Name/Relationship *(Type, Print)*: Mr. Thomas Sperling

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10623 Millet Seed Hill Columbia, Maryland 21044

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or othar pieca)*: All County Cremation Services, Inc.

Date: 01/25/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Timothy S. Hallein M0113

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Ovarian Cancer — years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying cause given in Part I.

HTN

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other *(Specify)* hospice

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, tarm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Deborah Gordon MD

29c. License number: D0051926

29d. Data signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon MD 6565 N. Charles St. Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1-24-01 0815

Sperling, Elizabeth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): **Rita Marian Shifflett**

2. Date of Death: Month: Jan Day: 18 Year: 2001

3. Time of Death: 9:55 PM

4a. Facility Name (If not institution, give street and number): Levindale Hebrew Geriatric Center & Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-28-4435

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 12, 1927

9. Birthplace (State or Foreign Country): Latvia, Russia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 3626 Eitemiller Rd.

10f. Zip Code: 21244

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Retail/Grocery

17. Father's Name (First, Middle, Last): Israel Getz

18. Mother's Name (First, Middle, Maiden Surname): Rebecca (not known)

19a. Informant's Name/Relationship (Type, Print): Mr. Alan L. Shifflett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3626 Eitemiller Rd. Baltimore, MD 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Lakeview Memorial Park

Date: 01/21/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Timothy S. Slack

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harold Bob MD

29c. License number: D15872

29d. Date signed (Month, Day, Year): JAN 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harold Bob 25 Main Street Westminster Maryland 21136

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Rita Shifflett

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM #20b per fh G791 012901 SS

Reg. No. 2001 021101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Kirkor Sekercan	January 24, 2001	4:23 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
029-30-0381	1☒ M 2☐ F	76 Yrs.			May 01, 1924	Istanbul, Turkey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore Co.	Towson	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1209 Limekiln Road	21286	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	08	Anesthesiologist	Physician/ Anesthesiology

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Abraham Sekercan	Maryam Elizabeth Unknown

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jeannette(nee Chirinian)Sekercan(Wife)	1209 Limekiln Road Towson, Maryland 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Corporation	1-29-01 ~~01/26/2001~~	Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ Jeffrey L. Gair, Sr. Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Glioblastoma Multiform	Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M. Gordon MD	D0051926	1/24/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen M. Gordon MD 6565 N. Charles, Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 29 2001	▶ Jenna D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Sekercan, Kirkor January 24, 2001 4:23 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02102

Selfridge, Melvin

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin Harrison Selfridge

2. Date of Death: Month JANUARY Day 25 Year 2001

3. Time of Death: 10:20 PM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 156-07-4558

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): October 12, 1920

9. Birthplaca (State or Foreign Country): New Jersey

Usual Residence of Decedant

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 8820 Walther Blvd. #208

10f. Zip Code: 21234

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Aircraft company

17. Fathar's Nama (First, Middla, Last): Harrison Selfridge

18. Mothar's Nama (First, Middle, Maiden Surname): Margaret McKewan

19a. Informant's Neme/Relationship (Type, Print): Audrey Selfridge-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 8820 Walther Blvd., #208, Baltimore, MD 21234

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or othar placa): Moreland Memorial Park

Data: 1/27/01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signatura of Funeral Service Licensee: William G. Dau

22. Nema and Addrass of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications thet caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiratory errast, shock, or heert failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Deeth

Immediata Causa (Final disaasa or condition resulting in death): a. Metastatic adenocarcinoma of stomach 2 weeks

Dua to (or as a consequance of): & distal esphagus

Sequentially list conditions, if any, laading to immediete causa. Entar Underlying Cause (Diseese or Injury that initiated evants rasulting in death) Last

b. Due to (or as a consequence ot):

c. Dua to (or as a consequanca of):

d.

Part II. Other signiffcant conditfons contributing to death but not rasulting in the underlying cause givan in Part I.

Myelodysplasia

23b. Dfd tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical axaminar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only ona): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigetion 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and placa, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar statad.

29b. Signeture end title of certifier: M.D.

29c. Licansa number: D52197

29d. Data signed (Month, Day, Year): 01-26-2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): REKHA MOTAGI, GBMC 6701 N. CHARLES ST. BALTIMORE, MD 21204

State Registrar

31. Data filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02103

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George J. Schaefer
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 8:07 am
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 173-07-5501
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 21, 1915
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1115 C Country Terrace Road
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Manufacturer

17. Father's Name (First, Middle, Last): George Schaefer
18. Mother's Name (First, Middle, Maiden Surname): Mary Manning

19a. Informant's Name/Relationship (Type, Print): Carl E. Schaefer-son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 C Country Terrace Rd., Baltimore, MD 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wildwood Cemetery
Date: 1/29/01
20c. Location - City or Town, State: Williamsport, PA

21. Signature of Funeral Service Licensee: William G. Dau
22. Name and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	6h.
Due to (or as a consequence of): b.	Coronary artery disease	20yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Diabetes mellitus	20 yrs
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P Papadatos
29c. License number: D0028949
29d. Data signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PANAYIOTIS Baltatzis MD 1232 RACE Rd. Balto MD 21237

State Registrar

31. Data filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 17 per informant G792 2/2/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02104

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothea Elizabeth Stocks

2. Date of Death: Month January Day 27 Year 2001

3. Time of Death: 4:35AM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-05-9420

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 16 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Sparks

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 45 Old Forge Garth

10f. Zip Code: 21152

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fether's Name *(First, Middle, Last)*: ~~Thomas A. When~~ Thomas A. Wehn

18. Mother's Neme *(First, Middle, Maidan Surnama)*: Mary C. Butcher

19a. Informant's Neme/Reletionship *(Type, Print)*: Wilhelmina E. Bickford/ Daughter

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stata, Zip Code)*: 45 Old Forge Garth Sparks, Md. 21152

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removet from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Nema of cemetery, cremetory or other place)*: Dulaney Valley Memorial Gardens

Dete: 1-30-01

20c. Location - City or Town, State: Timonium, Md.

21. Signeture of Funeral Service Licensee: Kurt J. Pough

22. Neme end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha deeth. Do not anter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Causa (Finel diseese or condition resulting in deeth)

a. BREAST CANCER

Due to (or es a consequance of):

Sequentially list conditions, if any, leeding to immadiata ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated evants rasulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and piece, end due to the cause(s) end mennar stated.

29b. Signeture end title of certifier: Jan 22

29c. Licensa number: D43725

29d. Dete signed *(Month, Day, Year)*: 1/29/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 29 2001

32. Registrer's Signeture: James G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

JANUARY 27, 2001 4:35 a.m.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DOROTHEA STOCKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02105

AMENDED ITEM #26 & 2 per phys G791 012901 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Claudia Simmant

2. Date of Death: Month 01 Day ~~27~~ 26 Year 01

3. Time of Death: 10:30pm

4a. Facility Name (If not institution, give street and number): 224 Ferndale Ave.

4b. City, Town, or Location of Death: Ferndale

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-38-7153

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 17, 1942

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Ferndale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 224 Ferndale Ave.

10f. Zip Code: 21061

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Work

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Horace Hatmaker

18. Mother's Name (First, Middle, Maiden Surname): Irene Smith

19a. Informant's Name/Relationship (Type, Print): Mr. Ronald F. Simmont, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 Ferndale Ave. Ferndale, MD 21061

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: January 27, 2001

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kirkley-RUddick Funeral Home P.A. 421 Crain Hwy. S.E. GLen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. respiratory failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. progressive supranuclear palsy 2½ years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) ~~home~~ hospice

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 048082

29d. Date signed (Month, Day, Year): 1/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): suite 212 11085 Little Patuxent Parkway Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Anthony Sweeney

2. Date of Death — Month: January Day: 25 Year: 2001

3. Time of Death: 11:00

4a. Facility Name (If not institution, give street and number): ST. Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 479-01-4331

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): 07/16/1911

9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): College (1-4or 5+): 4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Traffic Manager

16b. Kind of Business/Industry: Seagram

17. Father's Name (First, Middle, Last): John Sweeney

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth McDonald

19a. Informant's Name/Relationship (Type, Print): Charles Sweeney-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 318 Manor, Hanover, Pennsylvania, 17331

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/Wash. Crematory

Date: 01/31/01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Bernard Dalnoski

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue, Catonsville, Maryland, 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 4 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Medical Resident

29c. License number: P13604

29d. Date signed (Month, Day, Year): January, 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Offei Addo, MD 900 Caton Avenue, Baltimore, Md 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Bernard G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Sweeney, Joseph A.

15

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #19B PER F.H. G792 2-2-01 WR.

Certificate of Death

Reg. No. 2001 02107

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Carroll George Schreiner

2. Date of Death — Month: January Day: 24 Year: 2001

3. Time of Death: 11:35pm

4a. Facility Name *(If not institution, give street and number)*: Veterans Affairs Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-24-1372

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Oct. 7, 1929

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1 West Conway Street Apt. 805

10f. Zip Code: 21201

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-53

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 6 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Crown Cork and Seal Co.

17. Father's Name *(First, Middle, Last)*: George J. Schreiner

18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma L. Smith

19a. Informant's Name/Relationship *(Type, Print)*: Betty Kozlowski (Sister)

19b. Malling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1 West Conway Street APT. 910 ~~Apt 805~~, Balto. Maryland 21201

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Cemetery

Date: 01-26-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Pamela H. Nagymo

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Squamous cell lung cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Couid not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 [ ] **Medical Examiner**: On the besis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Pamela H. Nagymo

29c. License number: P13616

29d. Date signed *(Month, Day, Year)*: January 25 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Pamela H. Nagy 22 S. Greene St Baltimore MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrer's Signeture: Geneva G. Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #26 PER PHY G791 1-29-01 WR. *Certificate of Death* Reg. No. 2001 02108

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Curtis Sparkman
2. Date of Death Month Jan Day 23 Year 2001
3. Time of Death: 6:50 P.M.
4a. Facility Name (If not institution, give street and number): 4216 Audrey Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 402-26-8148
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 3, 1923
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4216 Audrey Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Boss-Linco

17. Father's Name (First, Middle, Last): John D. Sparkman
18. Mother's Name (First, Middle, Maiden Surname): Isabelle Frazier

19a. Informant's Name/Relationship (Type, Print): Patricia E. Sparkman (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4216 Audrey Avenue, Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. National Mem. Park
Date: 01-27-01
20c. Location - City or Town, State: Laurel Maryland

21. Signature of Funeral Service Licensee: John D. Sparkman
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ischemic Cardiomyopathy — 10 years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: MD 16664
29d. Date signed (Month, Day, Year): 01/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Young-Hyman MD 7201 Oakwood Rd Glenn Dale MD 20769

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Geneva G. Sparks

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#10a,20b perFHG791 1/29/01 EW

Certificate of Death

Reg. No. 2001 02109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DELOIS SATCHELL

2. Date of Death Month: 1 Day: 25 Year: 2001

3. Time of Death: 332 am

4a. Facility Name (If not institution, give street and number): Mariner Health of Catonsville

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 230-52-5287

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUN 24, 1938

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: ~~NY~~ MD

10b. County: N/A

10c. City, Town or Location: NEW YORK CITY

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 219 W. 144TH ST. APT. 23

10f. Zip Code: 10030

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER'S AIDE

16b. Kind of Business/Industry: SCHOOL

17. Father's Name (First, Middle, Last): ROBERT SMITH

18. Mother's Name (First, Middle, Maiden Surname): HELEN SMITH

19a. Informant's Name/Relationship (Type, Print): RANDOLPH SATCHELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10625 SAINWOOD COURT LAUREL MD 20723-7761

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. HOPE CEM.

Date: 1/30/01

20c. Location - City or Town, State: Hastings on Hudson, NY

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: GARY F. MARCH FUNERAL HOME P.A. 270 FREDERICK RD BALT. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute myocardial infarction — Approximate Interval: WKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN
DM II
Recent Respiratory arrest & failure s/p Tracheostomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Attending MD

29c. License number: D36942

29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. TURAKHIA, MD 1009, Frederick Rd, Baltimore, MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): **Joyce Barbara Tarricone**

2. Date of Death (Month, Day, Year): Jan 17, 2001

3. Time of Death: 23:47

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 144-38-5706

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 2, 1947

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3572 Blackberry Lane

10f. Zip Code: 21042

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Special Needs Teacher

16b. Kind of Business/Industry: Howard County Pulbic

17. Father's Name (First, Middle, Last): Albert Bevers Kilmer

18. Mother's Name (First, Middle, Maiden Surname): Helen Winifred Kosowski

19a. Informant's Name/Relationship (Type, Print): Mr. Arthur A. Tarricone, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3572 Blackberry Lane Ellicott City, Maryland 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Anne's Cemetery

Date: 01/25/01

20c. Location - City or Town, State: Spring Lake, New Jersey

21. Signature of Funeral Service Licensee: ▶ Timothy S. Hannan

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — One hour

Due to (or as a consequence of):
b. Coronary Artery Disease — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rita E. King MD, F.A.C.C.

29c. License number: M30294

29d. Date signed (Month, Day, Year): Jan 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Rita King 11085 Little Patuxent PKwy Columbia, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: ▶

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02111

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert TAYLOR
2. Date of Death Month: January Day: 26 Year: 2001
3. Time of Death: 0930
4a. Facility Name *(If not Institution, give street and number)*: Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 218-14-7905
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 25, 1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3558 Mt. Ida Drive
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unk; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook
16b. Kind of Business/Industry: Food Service

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Charlotte Ann Johnson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3558 Mt. Ida Drive Ellicott City, Maryland 21043

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Good Shepherd Cemetery — Date: 02/01/01
20c. Location - City or Town, State: Ellicott City, Maryland

21. Signature of Funeral Service Licensee: Timothy S. Hill — MO1113
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sepsis	2 weeks
	Due to (or as a consequence of): Diabetes	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive lung disease; Prostate cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dan A Moore MD
29c. License number: D21662/1461
29d. Date signed *(Month, Day, Year)*: January 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Carry Moore 6334 Cedar Lane Columbia, MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: Jennie G Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald W. Thurlow, Sr.

2. Date of Death (Month, Day, Year): JANUARY 25, 2001

3. Time of Death: 09:09 PM

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-1931

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 31 1921

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 12300 Rosslair Rd. #203

10f. Zip Code: 21093

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): +4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Industrial Engineer

16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Percy S. Thurlow

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Degan

19a. Informant's Name/Relationship (Type, Print): Katharine Thurlow/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12300 Rosslair Rd. #203 Timonium, Md. 21093

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Co.

Date: 1-27-01

20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: Kurt J. Laughy

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — DAYS

Due to (or as a consequence of):

b. PNEUMONIA — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. J. Helou M.D.

29c. License number: D 17695

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDALLAH J HELOU, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended ITEMS#7,8,15,17,18,20b perFHG792 2/8/2001 EW
Amended Item#25 perPHYG791 1/29/01 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth A Tremper
2. Date of Death (Month, Day, Year): January 9 2001
3. Time of Death: 2:15 am
4a. Facility Name (If not institution, give street and number): Forest Haven Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219 56 5520
6. Sex: 1☐ M 2☐ F X
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 8, 1908
9. Birthplace (State or Foreign Country): Taylorsville, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1☐ Yes 2☐ No X
10e. Street and Number: 6018 Ebenezer Road
10f. Zip Code: 21162
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Housekeeping-Own Home

17. Father's Name (First, Middle, Last): John Kroening
18. Mother's Name (First, Middle, Maiden Surname): Anna RIgler

19a. Informant's Name/Relationship (Type, Print): Donald H Tremper (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6018 Ebenezer Road White Marsh, Maryland 21162

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: Jan 12,01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Lassahn Chojnacki
22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CEREBRO VASCULAR
Due to (or as a consequence of): DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No X
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D28595
29d. Date signed (Month, Day, Year): 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM AKHTAR 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JagJit S. Tuli
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 5:30PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: UNK
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/10/1920
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 66 Corona Court
10f. Zip Code: 20905
10g. Citizen of What Country?: India (has green card)

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Indian/Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Broker
16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): S. Din Dayal Singh Tuli
18. Mother's Name (First, Middle, Maiden Surname): Ishwar Kaur Tuli

19a. Informant's Name/Relationship (Type, Print): Sukhraj Tuli-son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 66 Corona Court, Silver Spring, MD., 20905

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/Wash.Crematory
Date: 01/28/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Lyni Schlange MD 20
22. Name and Address of Facility: Fleck Funeral Home Inc. 7601 Sandy Spring Road Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
a. Myocardial infarction — weeks

Due to (or as a consequence of):
b. congestive heart failure — weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. pneumonia — days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings evailable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: RaDee MD
29c. License number: D50678
29d. Date signed (Month, Day, Year): 1/26/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): RAJEEV Batra M.D 12016 GEORGIA Ave - Wheaton, MD - 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signeture: Geneva G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Thomas Tyler Taylor, Sr.	January 22 2001	1:38 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Cranbrook Shopping Plaza	Cockeysville	Baltimore

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-44-1482	1 [X] M 2 [ ] F	57 Yrs.			February 10, 1943	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Cockeysville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10708 Lakespring Way	21030	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	stock broker	financial

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Bruce Taylor	Sophie Tyler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rachel Taylor/daughter	5038 Beachside Pl. Sherrills Ford, NC 28673

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cremetory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Greenmount Crematory	1/25/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John D. Mitchell IV	Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on aach line.

Approximata Interval Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Occlusion

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Liva birth 2 [ ] Fatal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of daath 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Ware autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only ona)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Othar (Specify) Public Street

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yas 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To tha bast of my knowledga, deeth occurrad at the time, date and place, and dua to tha cause(s) end manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Charles F. O'Donnell MD	D-09383	January 22, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print)

Charles F. O'Donnell MD 711 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 29 2001	Barbara L. Jones

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

01-0404-510
CJ
Arthur Shawn Word

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02116

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur Shawn Word

2. Date of Death — Month: January; Day: 24; Year: 2001

3. Time of Death: 06:10 P.M.

4a. Facility Name *(If not institution, give street end number)*: Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-94-4573

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 35 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Mar 07, 1965

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 814 East 22nd Street

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Merital Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Reca - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*

Elementery/Secondery (0-12): 12th

College (1-4or 5+): 2yrs

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Construction

17. Father's Neme *(First, Middle, Last)*: John Arthur Word

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Janice Patricia Blackwell

19e. Informant's Neme/Reletionship *(Type, Print)*: Janice P. Word (Mother)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 814 East 22nd Street Baltimore, Maryland 21218

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, crematory or other piece)*: King Memorial Park

Dete: 1/29/01

20c. Location - City or Town, Stete: Randallstown, MD.

21. Signature of Funeral Service Licensee: Dennis B Caple

22. Neme end Address of Feclity: Dennis B. Caple Funeral Home, P.A. 4601 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth)

a. Gunshot Wound of Head and Shoulder

Due to (or as a consequenca of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest

b.

Due to (or as e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings eveileble prior to completion of cause ot death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Deeth *(Check only one)*

Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 1/24/01

28b. Time of Injury: 1755 M

28c. Injury et Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject shot

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: STREET

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: 2000 Blk. Robb St.

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated. 2 [X] **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: J. Lorhead

29c. License number: O.C.M.E.

29d. Dete signed *(Month, Dey, Year)*: January 25, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 29 2001

32. Registrer's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02117

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mildred Wellslager

2. Date of Death: Month 01 Day 27 Year 01

3. Time of Death: 4:38 AM

4a. Facility Name *(If not institution, give street and number)*: Franklin Woods Nursing Home

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 139-12-2879

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 28, 1918

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6912 Fenway Rd

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12): 12 yrs; College (1-4or 5+): 4 Yrs.

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Baltimore County

17. Father's Nama *(First, Middle, Last)*: Richard M. Roberts

18. Mother's Name *(First, Middle, Meiden Surname)*: Mary Biggs

19a. Informant's Name/Relationship *(Type, Print)*: Ana Straw neice

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 108 Gothard Rd., Lutherville, Md. 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: Oaklawn Cemetery; Date: Jan 30, 2001

20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: ▶ Anthony C Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: Chronic Obstructive lung disease, Malnutrition, depression, hypertension anemia, hypopia

23b. Dtd tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straet, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Tom Edmondson MD

29c. Licensa number: D45766

29d. Data signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tom Edmondson, MD 9105 Franklin Square Dr, Ste. 312, Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: ▶ Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MINA VAN SICKLE

2. Date of Death: Month JAN Day 25 Year 2001

3. Time of Death: 6:20 PM

4a. Facility Name (If not institution, give street and number): Bon Secours Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: City

Funeral Director

5. Social Security Number: 219-14-7471

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28, 1906

9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17 E. Phlox Circle

10f. Zip Code: 21117

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 Grade

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aid

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Hamilton J. Crawford

18. Mother's Name (First, Middle, Maiden Surname): Leah M. Havner

19a. Informant's Name/Relationship (Type, Print): Edward H. Van Sickle (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4501 Oakview Lane Bowie, Md. 20715-1123

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Ser.

Date: 1/26/01

20c. Location - City or Town, State: Hampsyead, Md.

21. Signature of Funeral Service Licensee: Frank B Eline

22. Name and Address of Facility: ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 2 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arterio Sclerotic Cardio Vascular disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive pulmonary disease

Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sankaran

29c. License number: D 21649

29d. Date signed (Month, Day, Year): Jan 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMBANDAM SANKARAN 3455 WILKENS AVE, BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva B. Sparks

FEB 0 0 2001

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella F. Yirka
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 11:30 am

4a. Facility Name (If not institution, give street and number): Locust Lodge
4b. City, Town, or Location of Death: Riviera Beach
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-26-7965
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 10, 1910
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 184 Meadow Road
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Alexander Golas
18. Mother's Name (First, Middle, Maiden Surname): Anna Kolis

19a. Informant's Name/Relationship (Type, Print): Florence Martin (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Rugby Avenue, Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): Cedar Hill Cemetery
Date: 01-27-01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McGarity-Polyniak Funeral Home P.A. 237 East Patapsco Ave, Baltimore, Maryland 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Altzheimer's Disease	8 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Colvin C Carter MD
29c. License number: D01459
29d. Date signed (Month, Day, Year): Jan. 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Colvin Carter 4710 Pennington Ave. Baltimore Md. 21226

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

0220

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02120

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
KELLY CLIFTON ANDERSON	January 11, 2001	2:20 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	Havre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
246-22-3158	1☒M 2☐F	76 Yrs.			May 18, 1924	N. Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Darlington	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1818 Castleton Road	21034	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
4		Carpenter	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Kelly Alexander Anderson	Sara Jane Watson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Jane Wilson - Daughter	1818 Castleton Rd., Darlington, Maryland 21034

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	New Bridge Baptist Cem.	1/14/01	Colora, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Monte A. Emrey	McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. pneumonia.	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident

Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Hong Jun Kim	D37364	January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19 Walnut Lane, Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ANDERSON, KELLY

BH

1-11-00

DR. H. Kim

5

215-18-9016

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mae Iottie Brittingham
2. Date of Death (Month, Day, Year): 1/12/2001
3. Time of Death: 1615
4a. Facility Name (If not institution, give street and number): Waterview Healthcare Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 215-18-9016
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/04/1906
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1514 Riverside Dr. Pine Bluff Village
10f. Zip Code: 21801
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Sewell H. Brittingham
18. Mother's Name (First, Middle, Maiden Surname): Ida Lee Rayne

19a. Informant's Name/Relationship (Type, Print): Frank L. Brittingham - nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35870 Richland RD, Willards, MD 21874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other): Buckingham Presbyterian Cemetery
Date: 1/15/01
20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: ▶ Wm Eric Burbage
22. Name and Address of Facility: The Burbage Funeral Home 108 William Street Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DEHYDRATION — 7 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCVD
CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? NA 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mahesh Moondra
29c. License number: D32014
29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA 106 MILFORD ST 504 B SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02122

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUBREY BLADES BISHOP, SR.

2. Date of Death: Month 1 Day 10 Year 2001

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): 11915 Gray's Corner RD

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 220-26-8747

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/23/33

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11915 Gray's Corner RD

10f. Zip Code: 21811

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): John Blades Bishop

18. Mother's Name (First, Middle, Maiden Surname): O. Agnes Bradford

19a. Informant's Name/Relationship (Type, Print): Aubrey Bishop, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11915 Gray's Corner RD Berlin, MD 21811

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverside Cemetery

Date: 1/13/01

20c. Location - City or Town, State: Libertytown, MD

21. Signature of Funeral Service Licensee: W. Fitz Burbage

22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. respiratory failure	days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. chronic obstructive pulmonary disease	10 yr
	Due to (or as a consequence of):	
	c. AND interstitial lung disease	10 yr
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer of lung suspected not proven

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Nagel MD

29c. License number: D 22160

29d. Date signed (Month, Day, Year): 01-11-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM J NAGEL, MD Peninsula Regional Med. Ctr Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Geneva G. Sparks

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DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Marybeth	Borrell	January 9, 2001	6:30 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2410 Stoneybrook Road	Fallston	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-88-0783	1☐ M 2☒ F	34 Yrs.			August 1, 1966	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Fallston	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2410 Stoneybrook Road	21047	U.S.A.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Office Manager	Jewelry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Maschke	Helen Naumann

19a. Informent's Name/Reletionship (Type, Print) (parents)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. and Mrs. George Maschke	2410 Stoneybrook Road, Fallston, Maryland 21047

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)	Bel Air Mem. Gardens	1/12/01	Bel Air, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ Christina L Daniel	Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Road, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Sclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], Attending Neurologist	D35358	1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christopher T. Bever, Jr., MD., 22 S. Green St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 11 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Larry Curtis Black
2. Date of Death: Month Jan. Day 12 Year 2001
3. Time of Death: 1723
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 194-42-5964
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/09/1951
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 554 Franklin St.
10f. Zip Code: 21078
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Landscape Designer
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Lee R. Black
18. Mother's Name (First, Middle, Maiden Surname): Winnie M. Badger

19a. Informant's Name/Relationship (Type, Print): Monica M. Black- Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 554 Franklin St., Havre de Grace, MD 21078

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Erin Cemetery
Date: 1/17/01
20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: ▶ Sylvaine M. Smith
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Respiratory Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c. Metastatic Squamous Cancer
Due to (or as a consequence of):
d. Congestive Heart Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yea 2 [ ] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ MD
29c. License number: D20661
29d. Dete signed (Month, Day, Year): 1/3/01

30. Name and address of person who completed cause of death item 23a) (Type, Print): F. Lee M.D. 669 Revolution St. Havre de Grace, MD 21078.

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LARRY BLACK 1-12-01 1723 12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02125

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Nora Lyons Bargman

2. Dete of Deeth — Month: Jan. Dey: 15 Yeer: 2001

3. Time of Death: 7:36 pm

4e. Facility Neme *(If not institution, give street and number)*: Mallard Bay Care Center

4b. City, Town, or Location of Deeth: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-07-7315

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Mar. 14 1918

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 208 Henry St.

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐Never Merried 2☐Merried 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Neme *(First, Middle, Last)*: Oscar Lyons

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Nora Carey

19e. Informent's Neme/Reletionship *(Type, Print)*: Margaret A. Short-daughter

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 208 Henry St., Cambridge, MD 21613

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Greenlawn Cemetery

Dete: 1/18

20c. Location - City or Town, Stete: Cambridge, Maryland

21. Signeture of Funerel Service Licensee: ▶ [signature]

22. Neme end Address of Fecility: Thomas Funeral Home PA, 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

a. Cerebro vascular Accident — 2 weeks

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Degenerative Arthritis

23b. Did tobecco use contribute to the ceuse of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end ploce, end due to the ceuse(s) and menner es stated. 2☐**Medical Examiner:** On the basis of exemineticn and/or Investigetion, in my opinion, death occurred et the time, dete end ploce, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ [signature] M.D.

29c. License number: D0014349

29d. Dete signed *(Month, Dey, Yeer)*: 1/16/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Eyup Tanman 15 Franklin St. Cambridge, MD 21613

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 17 2001

32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie Britto

2. Date of Death Month Day Year: January 24, 2001

3. Time of Death: 12:25 pm

4a. Facility Name (If not institution, give street and number): Morningside House of Laurel

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 062-09-3357

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 18 1914

9. Birthplace (State or Foreign Country): Sicily

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 501 Main Street #232

10f. Zip Code: 20707

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Pasquale Leanza

18. Mother's Name (First, Middle, Maiden Surname): Guissippina Merlino

19a. Informant's Name/Relationship (Type, Print): Pat Wagner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 677 Old Waugh Chapel Road, Odenton, MD 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Date: 01/27/01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: G S K — M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Kundrat

29c. License number: D36716

29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Andrew Kundrat, MD 8317 Cherry Lane , Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02127

John Barcus

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): JOHN CHARLES BARCUS
2. Date of Death (Month, Day, Year): January 5, 2001
3. Time of Death: 2110
4a. Facility Name (If not institution, give street and number): Memorial Hospital Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-14-3497
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 14, 1920
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: CENTREVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 401 WATER ST.
10f. Zip Code: 21617
10g. Citizen of What Country?: USA
11. Marital Status: 1 [XX] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [XX] Yes 2 [ ] No — If Yes, Give Yeer or Detes: WW II
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [XX] No Specify:
14. Reca - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 3; College (1-4or 5+): -0-
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): NONE
16b. Kind of Business/Industry: NONE
17. Father's Neme (First, Middle, Last): WILLIAM JAMES BARCUS
18. Mother's Neme (First, Middle, Meiden Surneme): ALICE ROUSIE STOREY
19a. Informant's Neme/Reletionship (Type, Print): NELLIE REGINA SHORTALL/SISTER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 45.7 BOX 130, LEWES, DELAWARE
20a. Method of Disposition: [XX] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): MD. VETERAN CEMETERY
Dete: 1-10-2001
20c. Location - City or Town, Stete: HURLOCK, MD
21. Signeture of Funerel Service Licensee: Thomas K. Helfenbein
22. Name end Address of Fecility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line. — Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death)
a. Gastro intestinal bleed — 24 hrs
Due to (or es e consequence of):
b. Ischemic bowel
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Last
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) and manner es steted. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Noel Hunte MD
29c. License number: D 0055225
29d. Date signed (Month, Day, Year): 1/6/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): NOEL L. HUNTE, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

State Registrar

31. Dete filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
LEE LESLIE CHELTON	01	14	01	07:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
720 10th Street--Apt#9	Pocomoke	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
223-24-7025	1☒ M 2☐ F	87 Yrs.			06-26-13	Saxis, VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Pocomoke	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
720 10th Street--Apt#9	21851	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		Waterman	Seafood

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lee Clarence Chelton	Corbie Linton

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth F. Chelton	720 10th Street--Apt#9 Pocomoke, MD 21851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Downings Cemetery	1-17-01	Oak Hall, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ James N Fox	Fox Funeral Home P.O.Box 278 Temperanceville, VA 23442

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Parkinson's Sm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Mediastinal Adenopathy
Renal Insufficiency.
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D-54422	1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sarad Baral 1604 Market Street Pocomoke, MD 21851

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ Brenda B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02129

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Peggy Himes Craig

2. Date of Death Month / Day / Year: JANUARY 9, 2001

3. Time of Death: 1:44 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-32-4230

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 31, 1934

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 359 Revolution Street

10f. Zip Code: 21078

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Contractor

16b. Kind of Business/Industry: School Bus

17. Father's Name *(First, Middle, Last)*: James R. Himes

18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys J. Lawrence

19a. Informant's Name/Relationship *(Type, Print)*: Gail W. Reeder

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 418 Market Street, Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rock Run Cemetery

Date: 1/13/01

20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYTHMIA — MINUTES

Due to (or as a consequence of):

b. PULMONARY EMBOLI — 1 HOUR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY BYPASS GRAFT SURGERY

Due to (or as a consequence of):

d. CORONARY ARTERY ATHEROSCLEROTIC HEART DISEASE — YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven R. Axe MD

29c. Licensa number: D 34543

29d. Date signed *(Month, Day, Year)*: 1-10-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN R. AXE, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

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State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: Regina B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02130

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John C. Claiborne
2. Date of Death: Month: January; Day: 5; Year: 2001
3. Time of Death: 1550
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-26-7818
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/6/1929
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: PA.
10b. County: York
10c. City, Town or Location: New Park
10d. Inside City Limits: 1 ☐ Yes 2 X No
10a. Street and Number: 2436 New Park Road
10f. Zip Code: 17352
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Harford County Highways Dept.

17. Father's Name (First, Middle, Last): John Ernest Claiborne
18. Mother's Name (First, Middle, Maiden Surname): Eva Love Bailey

19a. Informant's Name/Relationship (Type, Print): Mildred M. Claiborne/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10 a,b,c,e,f

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Mem. Gardens
Date: 1/10
20c. Location - City or Town, State: 2001 Bel Air, Maryland

21. Signature of Funeral Service Licensee: E. Gladden Kurtz III
22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Coronary Artery Disease
Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. Acute Respiratory Distress Syndrome
Due to (or as a consequence of):
d. Renal Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: 013115
29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lance Uradomo, MD 22 S. Greene St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 1 - 2001
32. Registrar's Signature: B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02131

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DELORIS ANNE COLE

2. Date of Death Month Day Year: JANUARY 7, 2001

3. Time of Death: 1755

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 333-26-2009

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 2, 1936

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 30545 Cannon Drive

10f. Zip Code: 21804

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): –

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Clerk

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Lester Fox

18. Mother's Name *(First, Middle, Maiden Surname)*: Olivine Hewlett

19a. Informant's Name/Relationship *(Type, Print)*: Peter Allen Cole/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 30545 Cannon Dr., Salisbury, MD 21804

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Salisbury Crematory

Date: 1/8/01

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: ▶ Keith R Demey CFSP

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Compression Fractures

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Roger C Merrill MD

29c. License number: D21953

29d. Date signed *(Month, Day, Year)*: 1/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROGER C. MERRILL, MD 100 POWER STREET, SALISBURY, MD. 21804

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

333-26-2009

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DELORIS A. COLE

bmf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02132

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MADALEAN CUPPET
2. Date of Death Month / Day / Year: 1/21/01
3. Time of Death: 6:30AM
4a. Facility Name *(If not institution, give street and number)*: DEVLIN MANOR NURSING HOME
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGHENY

Funeral Director

5. Social Security Number: 214-07-2567
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5/30/19
9. Birthplace *(State or Foreign Country)*: CUMBERLAND, MD

Usual Residence of Decedent

10a. State: WV
10b. County: MINERAL
10c. City, Town or Location: RIDGELEY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 29 MINERAL STREET
10f. Zip Code: 26753
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: CLIFFTON ROBERT ZOLLNER
18. Mother's Name *(First, Middle, Maiden Surname)*: ETHEL LEE ZOLLNER

19a. Informant's Neme/Relationship *(Type, Print)*: ALAN CUPPETT/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 601, RIDGELEY, WV 26753

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OMEGA CREMATORY
Date: 1/25/01
20c. Location - City or Town, State: MORGANTOWN, WV

21. Signature of Funeral Service Licensee: Robert J. Bolyard
22. Name and Address of Facility: WVU HGR, P.O. BOX 9128, MORGANTOWN, WV 26506

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE LUNG DISEASE — 5 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PULMONARY FIBROSIS; ARTERIOSCLEROTIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robustiano J. Herrera, J.
29c. License number: D-14865
29d. Date signed *(Month, Day, Year)*: JAN. 21st, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBUSTIANO J. BARRERA MD. CUMBERLAND, MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LINWOOD ARTHUR LEE DISHAROON
2. Date of Death (Month, Day, Year): JANAURY 11, 2001
3. Time of Death: 6:45 AM
4a. Facility Name (If not institution, give street and number): 115 PRISCILLA STREET
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-34-9154
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 1, 1937
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 115 PRISCILLA STREET
10f. Zip Code: 21804
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PAINTER
16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name (First, Middle, Last): LINWOOD A. DISHAROON
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY LEE ROBERTSON

19a. Informant's Name/Relationship (Type, Print): B. KEITH DISHAROON - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7232 PARSONS COURT ALEXANDRIA, VA 22306

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CAMBRIDGE CREMATORY
Date: 1/12/01
20c. Location - City or Town, State: CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: B. Keith Disharoon OFSP
22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ATHEROSCEROTEC VESSEL DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERLIPIDEMIA

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ronald P. Travitz
29c. License number: D36576
29d. Date signed (Month, Day, Year): 1/11/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RONALD P. TRAVITZ MD 560 RIVERSIDE DR. SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3+1VA
DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02134

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SELDEN E. DOUGHTY

2. Date of Death (Month, Day, Year): JANUARY 12, 2001

3. Time of Death: 0355

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 187-05-9565

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 11, 1917

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1005 HERON CT.

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): METALLURGIST

16b. Kind of Business/Industry: STEEL COMPANY

17. Father's Name (First, Middle, Last): HENRY EMERSON DOUGHTY

18. Mother's Name (First, Middle, Maiden Surname): LAURA TWITCHELL

19a. Informant's Name/Relationship (Type, Print): DORIS M. DOUGHTY - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1005 HERON CT. SALISBURY, MD 21804

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CAMBRIDGE CREMATORY

Date: 1/13/01

20c. Location - City or Town, State: CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: Melissa Kay Henry

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia

Due to (or as a consequence of): Atrial fibrillation.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of): CVA

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DO

29c. License number: H54827

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MITCHELL GOTTLIEB, DO 106 MILFORD ST SUITE 201 SALISBURY MD 21804.

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Penina D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANE DELATOS
2. Date of Death (Month, Day, Year): 01 - 23 - 01
3. Time of Death: 12-37PM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 579-30-7791
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-20-24
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9010 Briarcroft Lane #325
10f. Zip Code: 20708
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Morris Benjamin Hartless
18. Mother's Name (First, Middle, Maiden Surname): Annie Byrd Tomlin
19a. Informant's Name/Relationship (Type, Print): Tammy Gomez/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7994 Milkstream Court, Elkridge, MD 21075
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Emmanuel UM Church Cem.
Data: 01/27/01
20c. Location - City or Town, State: Scaggsville, MD
21. Signature of Funeral Service Licensee: [signature] M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC LIVER DISEASE

Due to (or as a consequence of):
b. WITH MASSIVE ASCITES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. METASTATIC BREAST CANCER

Due to (or as a consequence of):
d. RIGHT BREAST.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
HYPERTENSION.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD.
29c. License number: D21294
29d. Date signed (Month, Day, Year): 01-23-01.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL NAYEEM, M.D. 3456-FORT MEADE ROAD, SUITE 100, LAUREL MD. 20724.

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

CK

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Golden Rogers Evans

2. Date of Death: Month JANUARY Day 16, Year 2001

3. Time of Death: 12:23PM

4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LA PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 213-24-2915

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 21, 1927

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: INDIAN HEAD

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6240 GREENWAY DRIVE

10f. Zip Code: 20640

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1946 1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): ISAIAH EVANS

18. Mother's Name (First, Middle, Maiden Surname): MARY PENDLETON EVANS

19a. Informant's Name/Relationship (Type, Print): ETHEL LOUISE POOLE EVANS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6240 GREENWAY DRIVE, INDIAN HEAD, MARYLAND 20640

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MARYLAND VETERANS CEM.

Date: 1/23/01

20c. Location - City or Town, State: CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular fibrillation — 1hr

Due to (or as a consequence of):
b. Coronary Artery disease — 10yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive Heart failure — 10yr

Due to (or as a consequence of):
d. Chronic Renal failure, Dialysis — 10yr

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L Berwa MD Attending

29c. License number: D-24535

29d. Date signed (Month, Day, Year): 01.16.01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): LAXMI N. BERWA, 7700 OLD BRANCH AVE., SUITE C-101, CLINTON, MD 20735

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES EDLEY

2. Date of Death: Month 01 Day 10 Year 01

3. Time of Death:

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 124-34-4575

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-24-45

9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedent

10a. State: MD. 10b. County: WORCESTER 10c. City, Town or Location: STOCKTON 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1502 APT. A P.O. BOX 3 10f. Zip Code: 21864 10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: BLACK

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): WILLIAM EDDLEY SR.

18. Mother's Name (First, Middle, Maiden Surname): LILLIAN MAE ASHTON EDDLEY

19a. Informant's Name/Relationship (Type, Print): GAIL KITTLE - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 - POBOX 3, STOCKTON, MD. 21864

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Jerusalem Baptist Church Date: 1-13-01 20c. Location - City or State: Temperanceville, VA

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Bennie Smith Funeral Home P.O. BOX 331 POCOMOKE, MARYLAND 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death:

Immediate Cause (Final disease or condition resulting in death): a. Congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Coronary artery disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D41721

29d. Date signed (Month, Day, Year): 01/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHAN PAVLOS MD 400 E. SHORE DR. SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

FRANCES EDLEY SS#124-34-4575 SSN 1-10-01 2145

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001-02138

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH COFFIN ENGLISH

2. Date of Death Month / Day / Year: January 11, 2001

3. Time of Death: 3:00 PM

4a. Facility Name *(If not institution, give street and number)*: Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 216-09-5920

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1/1/1914

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 202 A South Main St.

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper

16b. Kind of Business/Industry: Building & Loan Co.

17. Father's Name *(First, Middle, Last)*: Edward L. Coffin

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Krill

19a. Informant's Name/Relationship *(Type, Print)*: Ralph Doughty/ Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12808 Coastal Highway #108 Ocean City, MD 21842

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Churchyard St. Paul's Episcopal

Date: 1/15/01

20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: W. Fred Burbage

22. Name and Address of Facility: Burbage Funeral Home 108 William st. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — months

Due to (or as a consequence of):

b. Hypercalcemia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 025349

29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Elizabeth Coffin English

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOAN FISCINA

2. Date of Death Month Day Year: JANUARY 10, 2001

3. Time of Death: 1015

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 001-22-1511

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 6, 1929

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: FLORIDA

10b. County:

10c. City, Town or Location: INDIA LANTIL

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 627 PINETREE DRIVE

10f. Zip Code: 32903

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JAMES MARTIN

18. Mother's Name (First, Middle, Maiden Surname): EMILY WILLIAMSON

19a. Informant's Name/Relationship (Type, Print): DIANE F. FILLYAW - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD 3 BOX 191F LAUREL DE 19956

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or othar place): GATE OF HEAVEN CEMETERY

Date: 1/16/01

20c. Location - City or Town, Stata: HAWTHORNE, NEW YORK

21. Signature of Funeral Service Licensee: ▶ B. Kent Phynn CFSP

22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in deeth): a. CHF — 4days

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Endocarditis — 4days

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier: ▶ Robtaler, M.D.

29c. Licansa number: D29168

29d. Date signed (Month, Day, Year): 1/11/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Robert Allen, M.D. 560 Riverside Dr. A204 Salisbury, MD

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

JOAN FISCINA

10 DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02140

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecil Howard Fink
2. Date of Death: Month January, Day 9, Year 2001
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): 208 Diana Drive
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 233-16-8963
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 27, 1913
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5072 E. Federal St.
10f. Zip Code: 21205
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Chemical
17. Father's Name (First, Middle, Last): Emmit Fink
18. Mother's Name (First, Middle, Meiden Surneme): Louella Unknown
19a. Informent's Name/Relationship (Type, Print): Rose Marie Autry (Step-dghtr-inlaw)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 Diana Drive, Pasadena, Maryland 21122
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): Oak Lawn
Date: 1/13/01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licansee: ▶ [signature]
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final diseese or condition resulting in deeth) a.	Respiratory Failure	24 hours
Due to (or as a consequenca of): b.	Pleural Effusion	10 days
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequenca of): c.	Metastatic Cancer	3 months
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Liver Failure
Coronary Artery Disease
Anemia

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert G. Morrison, MD, PhD
29c. License number: D0048139 (Md.)
29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Robert G. Morrison, MD PhD 3301 Belair Rd. Baltimore, Maryland 21213

State Registrar

31. Dete filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02141

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Watson Fisher

2. Date of Death — Month: January; Day: 8; Year: 2001

3. Time of Death: 9:06 P.M.

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 234-07-1155

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 19, 1915

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Street

10d. Inside City Limits: [ ] 1 Yes [X] 2 No

10e. Street and Number: 1299 Macton Road

10f. Zip Code: 21154

10g. Citizen of What Country?: U.S.A.

11. Marital Status: [ ] 1 Never Married [ ] 2 Married [X] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [ ] 1 Yes [X] 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Welder

16b. Kind of Business/Industry: Oil Co.

17. Father's Name *(First, Middle, Last)*: Joseph Mineral Fisher

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie McDAniel DeWees

19a. Informant's Name/Relationship *(Type, Print)*: Betty Ashcraft (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1299 Macton Road, Street, Maryland 21154

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [X] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakeside Memorial Park — Date: 1/01

20c. Location - City or Town, State: Winter Haven, Florida

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	2 days
Due to (or as a consequence of): b.	Acute Pulmonary edema	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Renal Failure	1 month
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitis

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [X] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)*: Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA — Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other *(Specify)*

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D36715

29d. Date signed *(Month, Day, Year)*: January, 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHERIF H. OSMAN, M.D. 39 Churchville Rd. BEL AIR, MD 21015

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Joseph W. Fisher

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jasmine Rochelle Graves
2. Date of Death: Month JAN. Day 21, Year 2001
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: none
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours 3 / Min. 54
8. Date of Birth (Month, Day, Year): JAN 20, 2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Mount Rainier
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 3411 Newton Street
10f. Zip Code: 20712
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): none; College (1-4or 5+): none
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none - Infant
16b. Kind of Business/Industry: none - Infant

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Quinestine Carlina Graves

19a. Informant's Name/Relationship (Type, Print): Quinestine Carlina Graves/mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3411 Newton Street Mount Rainier MD. 20712

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): None
Date: 1/24/01
20c. Location - City or Town, State: Cheverly MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Route 301 Waldorf MD 20788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Extreme Prematurity (21 weeks gestation)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] MD
29c. License number: D27628
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Isabelita G. Frattarola MD, Prince George's Hospital Center, 3001 Hospital Dr., Cheverly, Md 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET JANE HILL

2. Date of Death: Month JANUARY Day 13, Year 2001

3. Time of Death: 4:30AM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 220-28-5545

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): OCT 28, 1934

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: CAPITOL HEIGHTS

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 512 DATELEAF AVENUE

10f. Zip Code: 20743

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): MCCALISTER JOHNSON

18. Mother's Name (First, Middle, Maiden Surname): LUCILLE VIRGINIA JOHNSON JOHNSON

19a. Informant's Name/Relationship (Type, Print): LAVERNE YATES-SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 KALMIA COURT, LAPLATA, MD 20646

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): SACRED HEART CEMETERY

Data: 1/20/01

20c. Location - City or Town, State: LAPLATA, MD

21. Signature of Funeral Service Licensee: LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. RENAL CELL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: BRONCHOGENIC CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: CESAR SORIANO JR.

29c. License number: D 0014468

29d. Data signed (Month, Day, Year): 01/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CESAR SORIANO JR. 119 CAPITOL HTS BLVD. CAPITOL HTS, MD 20743

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Data filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH VINCENT HALL
2. Date of Death: Month Jan. Day 11, Year 2001
3. Time of Death: 7:05 AM
4a. Facility Name (If not institution, give street and number): Salisbury Center; Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, Md.
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 579-24-6970
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March 19,1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5585 E. Nithsdale Drive
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II Navy
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Analyst
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Dent A. Hall
18. Mother's Name (First, Middle, Maiden Surname): Mary Elsie Thompson

19a. Informant's Name/Relationship (Type, Print): Elnora S. Hall/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5585 E. Nithsdale Dr., Salisbury, MD 21801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wicomico Memorial Park
Date: 1/13/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: ▶ Keith R Downey CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lung Cancer with mets
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: 028348
29d. Date signed (Month, Day, Year): 1/11/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William H. Robins, M.D. 1104 HEALTHWAY DR., SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JOSEPH HALL
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10+1VA
DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN BENSON HALL

2. Date of Death: Month January Day 15 Year 2001

3. Time of Death: 0820

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-20-5223

6. Sex: ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 95 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/26/1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3864 Grove Lane

10f. Zip Code: 21851

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): John Thomas Hall

18. Mother's Name (First, Middle, Maiden Surname): Amanda Lee Stevens

19a. Informant's Name/Relationship (Type, Print): Shirley Lawrence (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3932 Grove Lane, Pocomoke City, MD 21851

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): First Baptist Cemetery

Date: 1/18/2001

20c. Location - City or Town, State: Pocomoke City, MD

21. Signature of Funeral Service Licensee: Michael A Dean MO1129

22. Name and Address of Facility: Holloway Melson Funeral Home, P.A. 105 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Congestive Cardiomyopathy

Due to (or as a consequence of): AS/HD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other algcificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

-Ch. Renal Insuff.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nephrologist

29c. License number: 53611

29d. Date signed (Month, Day, Year): 1/15/01.

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print): RAZI S. KHAN 547-G Riverside Dr, Salisbury, MD 21801.

State Registrar

31. Dete filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John Hall 218-20-5223

5

01-0127-510
CJ
Thomas Holmes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02146

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Russell Holmes, III
2. Date of Death: Month: January; Day: 08; Year: 2001
3. Time of Death: 08:52 A.M.
4a. Facility Name *(If not institution, give street and number)*: 2813 O'Donnell Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-56-4379
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 50 rs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 14, 1950
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: ----------
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2813 O'Donnell Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/ Operator
16b. Kind of Business/Industry: Shipping Freight

17. Father's Name *(First, Middle, Last)*: Thomas Russell Holmes, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Marian Jane Wagner

19a. Informant's Name/Relationship *(Type, Print)*: Patricia H. Kettle / Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1202 Midwood Ct., Bel Air, MD 21014

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.
Date: 1-11-01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stella A. Hughes
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic

Due to (or as a consequence of):
Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. ☒

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* Scene

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Lakon Locke MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 9, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Lakon Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: Lawrence B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

bh

6

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Peggy Jean Hetterich

2. Dete of Death Month Day Year: January 8, 2001

3. Tima of Death: 2845pm

4e Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-32-0793

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)* Yrs.: 66

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 3, 1934

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3746 Elmora Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Bennie C. Yeomans

18. Mother's Name *(First, Middle, Maiden Surneme)*: Christine Dodson

19e. Informent's Neme/Reletionship *(Type, Print)*: Robert V. Hetterich (Husband)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3746 Elmora Avenue, Baltimore, Maryland 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremelion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Gardens of Faith

Dete: 1/11/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Fungral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)

a. Renal Failure — 4 Days

Due to (or as a consequence of):

b. Carcinosarcoma of Uterus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature] MD

29c. License number: 19671?

29d. Dete signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Maribeth Anderson MD 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hetterich, Peggy

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02148

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Woodrow E. Honey

2. Date of Death Month Day Year: January 18 2001

3. Time of Death: 1:45 PM

4a. Facility Name *(If not institution, give street and number)*: 10900 Montgomery Road

4b. City, Town, or Location of Death: Beltsville

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 161-16-5071

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 8, 1918

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10e. State: MD

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10900 Montgomery Road

10f. Zip Code: 20705

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-1945

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): Ø

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Master Mechanic

16b. Kind of Business/Industry: Refrigeration/Heating

17. Father's Neme *(First, Middle, Last)*: John Honey

18. Mother's Neme *(First, Middle, Meiden Surname)*: Mame Evans

19a. Informant's Neme/Relationship *(Type, Print)*: Gary Woodrow Honey/Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 47791 Blockhouse Point Place, Potomac Falls, VA 20165

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: 1/24/01

20c. Location - City or Town, Stete: Catonsville, MD

21. Signeture of Funeral Service Licensee: Gary S. Kyle M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Cerebrovascular Accident — 1 Week

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

b. Metastatic Squamous Cell Carcinoma of Skin — 2 Years

Due to (or as e consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Linda M Burrell MD

29c. License number: D35996

29d. Date signed *(Month, Day, Year)*: January 19, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Linda Burrell, MD 2730 University Blvd, 400. Silver Spring, MD 20902

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the **Hospital or Attending Physician:** The law requires that the deeth certificete be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

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State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02149

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Hall

2. Date of Death Month Day Year: January 24, 2001

3. Time of Death: 7:25 pm

4a. Facility Name *(If not institution, give street and number)*: 8427 Brock Bridge Road

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-36-9411

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 29 1938

9. Birthplace *(State or Foreign Country)*: Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8427 Brock Bridge Road

10f. Zip Code: 20724

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): Ø

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Editor

16b. Kind of Business/Industry: Arbitron Ratings Corp.

17. Father's Name *(First, Middle, Last)*: Lawrence Bernard Mack

18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys Marie Tydings

19a. Informant's Name/Relationship *(Type, Print)*: Warren Hall/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8427 Brock Bridge Road, Laurel, MD 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Meadowridge Memorial Pk

Date: 1/29/01

20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: M00773

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Pancreatic Carcinoma — 5 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James D. Brown, MD

29c. License number: D07285

29d. Date signed *(Month, Day, Year)*: January 25, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): James D. Brown, MD 9707 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Penny B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02150

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis J Kaisler

2. Date of Death (Month, Day, Year): January 23 2001

3. Time of Death: 8:56 AM

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 214 24 1288

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 23, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3033 Greenway Drive

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, afc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, afc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 4

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Mechanical-Optical Engineer

16b. Kind of Business/Industry: Defense Industry

17. Father's Name *(First, Middla, Last)*: John Joseph Kaisler

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Evelyn Smlsal

19a. Informant's Name/Relationship *(Type, Print)*: Christine M. Kaisler/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3033 Greenway Drive Ellicott City, MD 21042

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: St. John's Cemetery

Date: 1-27-2001

20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: Donna Collins-Wittle MD1044

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachline.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Malignant Arrhythmia — Sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred af tha time, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier:

29c. Licensa number: D22856

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jerry I Levine, MD 11050 Little Patuxent Pky, Columbia, MD 21044

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranait

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02151

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Pauline M. Kelch
2. Date of Death: Month January Day 23, Yeer 2001
3. Time of Death: 9:05 a.m.
4a. Facility Name (If not institution, giva street and number): Catonsville Commons
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220 09 6110
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. lest birthday): 91 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): May 26, 1909
9. Birthpleca (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 4962 Ilchester Point Court
10f. Zip Code: 21043
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indien, Bleck, Whita, etc. Specify: white

15. Decedent's Education (Specify only highest greda completed): Elementary/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Harvey R. Watkins
18. Mother's Neme (First, Middle, Maiden Surname): Pauline E. Abey

19e. Informent's Name/Relationship (Type, Print): Hilda R. Sawczenko/Sister
19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4962 Ilchester Point Court Ellicott City, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stata 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetary, cremetory or other pleca): Loudon Park
Date: 1-26-2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funerel Service Licensee: Helena Collins-Doyle MD1044
22. Nema and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23e. Part1. Enter the disaasa, or complicetions thet caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line. Approximete Intervel Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death): e. Myocardial Infarction
Due to (or es a consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest:
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure; Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to compiation of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end pleca, end due to tha ceuse(s) and menner stated.

29b. Signature and title of certifier: Shalini Tewari MD
29c. License number: D52 671
29d. Deta signed (Month, Dey, Year): January 24, 2001

30. Neme and eddress of parson who completed cause of death (Item 23a) (Type, Print): Shalini Tewari, M.D. / 1838 Greene Tree Rd / Suit 300 / Pikesville MD 21208

State Registrar

31. Dete filed (Month, Day, Year): JAN 29 2001
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours eftar daath.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as tha burial-transit permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(3)

Copy

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02152

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES FRANCIS LAWRENCE
2. Date of Death: Month 01 Day 09 Year 2001
3. Time of Death: 1:15 PM
4a. Facility Name *(If not institution, give street and number)*: 5310 MAIN STREET
4b. City, Town, or Location of Death: GRASONVILLE
4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 578-07-0588
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02/28/1916
9. Birthplace *(State or Foreign Country)*: D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: GRASONVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5310 MAIN STREET
10f. Zip Code: 21638
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MILKMAN
16b. Kind of Business/Industry: DAIRY

17. Father's Name *(First, Middle, Last)*: JOSEPH P. LAWRENCE
18. Mother's Name *(First, Middle, Maiden Surname)*: GURTRUDE LIESER

19a. Informant's Name/Relationship *(Type, Print)*: VIOLET K. LAWRENCE / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5310 MAIN STREET GRASONVILLE, MARYLAND 21638

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: STEVENSVILLE CEMETERY — Date: 1/12/01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Chad M. Helfenbein
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MARYLAND 21619

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Prostate Cancer — Due to (or as a consequence of): Type

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ralph S. Libby
29c. License number: D0005754
29d. Date signed *(Month, Day, Year)*: 1-10-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. RALPH LIBBY 204 MEDICAL CENTER ROAD GRASONVILLE, MARYLAND 21638

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROGER FRANCIS MARINER

2. Data of Death — Month: January Day: 9 Year: 2001

3. Time of Death: 1258

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-16-7217

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): 11/28/1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1019 Bishop Road

10f. Zip Code: 21851

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highast grada complatad)

Elementary/Secondary (0-12): 11

Collega (1-4or 5+):

18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Rural Mail Carrier

16b. Kind of Business/Industry: Public Service

17. Father's Name (First, Middle, Last): Esley Thomas Mariner

18. Mothar's Nama (First, Middle, Maiden Surnama): Effie Anna Howard Mariner

19a. Informant's Name/Ralationship (Type, Print): Roger Mason (nephew)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 1117 Cedar Hall Rd., Pocomoke City, MD 21851

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cremetory or othar place): First Baptist Cemetery

Data: 1/12/2001

20c. Location - City or Town, State: Pocomoke City, MD

21. Signature of Funaral Sarvice Licansee: Michael A Dean M01129

22. Nama and Address of Facility: Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Batwaen Onset and Death

Immediate Causa (Finat diseasa or condition resulting in death)

a. Ischemic cardiomyopathy

Dua to (or as a consaquance of):

Sequentially list condiltons, if any, laading to immadiate cause. Entar Underlying Cause (Disaase or injury that initiatad avants rasulting in death) Last

b. coronary artery disease

Dua to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Diabetes

Chronic obstructive pulmonary disease

renal insufficency

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☑ No

26. Placa of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidanca 8☐ Othar (Specify)

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and placa, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at the tima, date and placa, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Anthony V. Frey MD

29c. Licansa number: D0053394

29d. Data signad (Month, Day, Year): 1/10/01

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): ANTHONY FREY, M.D. 1315 S. DIVISION ST. SALISBURY, 21804

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signatura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

218-16-7217

Roger Mariner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CATHERINE MARTIN
2. Date of Death: Month JANUARY Day 12 Year 2001
3. Time of Death: 6:20PM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 214-22-7464
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 16, 1901
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3406 Grier Nursery Road
10f. Zip Code: 21154
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Andrew Jackson Long
18. Mother's Name (First, Middle, Maiden Surname): Jincey (nmn) Campbell

19a. Informant's Name/Relationship (Type, Print): Lilace Norris / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 W. Jarrettsville Rd., Forest Hill, MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | Date: 1-16-01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Charles A. Engel
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebral vascular accident — <14 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn
29c. License number: D3 2279
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 615 W. MacPhail

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Anna P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LUCILLE DEAN MERRITT
2. Date of Death: Month JAN. Day 7 Year 2001
3. Time of Death: 5:35PM
4a. Facility Name (If not institution, give street and number): SALISBURY CENTER: GENESIS ELDERCARE
4b. City, Town, or Location of Death: SALISBURY, MD
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-18-4851
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 2,1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 100 Civic Ave.
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8 College (1-4or 5+): –
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Richard Dean
18. Mother's Name (First, Middle, Maiden Surname): Lair Holiday

19a. Informant's Name/Relationship (Type, Print): Geneva Davis/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3855 St. Lukes Rd., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Wicomico Memorial Park
Date: 1/11/01
20c. Location - City or Town, State: Salisbury, MD

21. Signeture of Funeral Service Licensee: Kell R Downey CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of): b. Pneumonia — 3 Days
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last
Due to (or as e consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHF
S/P Pacemaker

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D-39813
29d. Date signed (Month, Day, Year): 1/8/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

State Registrar

31. Dete filed (Month, Day, Year): JAN 11 2001
32. Registrer's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

LUCILLE MERRITT
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02156

AMENDED ITEM #7 per fh G791 012901 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGUERITE Y. MEDLEY

2. Date of Death (Month, Day, Year): JAN. 2 2001

3. Time of Death: 10:05 am

4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-56-3862

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~52~~ 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 2 1947

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND | 10b. County: ANNE ARUNDEL | 10c. City, Town or Location: ANNAPOLIS | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1418 TYLER AVENUE | 10f. Zip Code: 21403 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): ARCHIE BLUNT

18. Mother's Name (First, Middle, Maiden Surname): MARGUERITE JOHNSON

19a. Informant's Name/Relationship (Type, Print): JOSEPH MEDLEY (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1418 TYLER AVE. ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): ANNAPOLIS MEM. GARDENS | Date: 1/5/01 | 20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: ▶ Larry G. Reese M00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. | Approximeta Intarval Between Onset and Death

Immedieta Causa (Final disaase or condition resulting in death)

e. Cerebral Vascular Accident

Due to (or es e consequence of):

Sequenfially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due fo (or as a consequence of):

c.

Due fo (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal Failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Aimee Yu

29c. License number: D55187

29d. Date signed (Month, Day, Year): January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aimee Yu 600 Ridgely Avenue, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 04 2001

32. Registrar's Signature: Brenda P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A.A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Maleonskie
2. Date of Death Month: January Day: 26, Year: 2001
3. Time of Death: 6:15 AM
4a. Facility Name (If not institution, give street and number): Baltimore Rehab/Extended Care, VAMC
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234-26-8317
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 05, 1918
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: W.V.
10b. County: Tucker
10c. City, Town or Location: Davis
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: Blackwater Avenue
10f. Zip Code: 26260
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): John Maleonskie
18. Mother's Name (First, Middle, Maiden Surname): Anna Fisher

19a. Informant's Name/Relationship (Type, Print): Ann Davis /niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18519 Bowie Mill Rd, Olney, Maryland 20832

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Calvary Catholic Cem — Date: 1/29/01
20c. Location - City or Town, State: Thomas, West Virginia

21. Signature of Funeral Service Licensee: [signature] M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 037070
29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J Loreck MD Balto VAMC Rehab / Extended Care

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: [signature] B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(12)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELSIE PARKER
2. Date of Death (Month, Day, Year): JAN 9 2001
3. Time of Death: 2119
4a. Facility Name (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: HAVRE DE GRACE
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 227-24-2843
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 21, 1924
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3154 Nova Scotia Road
10f. Zip Code: 21015
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Supervisor
16b. Kind of Business/Industry: Civil Service

17. Father's Name (First, Middle, Last): Lafayette Sexton
18. Mother's Name (First, Middle, Maiden Surname): Bertha Jones

19a. Informant's Name/Relationship (Type, Print): Linda Crocetti (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3154-A Nova Scotia Road, Bel Air, MD 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R. A. Ferris & Co., Inc.
Date: 1/11/01
20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pulmonary Fibrosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CARCINOMA BREAST

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: OME
29c. License number: OCME
29d. Date signed (Month, Day, Year): JAN 9 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPNABHU M-0728 BELAIR MD BELAIR MD 21014.

25

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Barbara P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend Item #1 HCHD 1/16/01 BRH

Reg. No 2001 02159

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Mary Pace~~ Mary Nancy Pace

2. Date of Death: Month 1 Day 12 Year 01

3. Time of Death: 10:38 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: ----------

Funeral Director

5. Social Security Number: 492-66-0350

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Mar. 14, 1962

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2905 Grafton's Lane

10f. Zip Code: 21028

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedenf's Educetion (Specify only highast grada completed): Elemantary/Secondary (0-12) ____ College (1-4or 5+) 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dental Assistant

16b. Kind of Business/Industry: Dental

17. Father's Nama (First, Middle, Last): Lee V. Drane

18. Mother's Nama (First, Middle, Meiden Surname): Mildred (nmn) Beall

19a. Informant's Name/Relationship (Type, Print): Jonathan Pace- Husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2905 Grafton's Lane, Churchville, Maryland 21028

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cematary, cramatory or othar piece): Cokesbury U.M. Cemetery

Data: 1/15/01

20c. Location - City or Town, State: Abingdon, Maryland

21. Signature of Funeral Service Licensee: ▶ Charles A. Emge

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Intarval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Multiple Myeloma ~12 mos

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequance of):

d. ____

P.H.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Renal Failuve

Malignant Plaural Effusion

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara sutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Chack only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D 52477

29d. Date signed (Month, Day, Year): 1/12/01

12+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aaron Rapoport, 22 S. Greene St. Balto. MD

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02160

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eullho Park
2. Date of Death: Month January Day 12 Year 2001
3. Time of Death: 10:16 P.M.
4a. Facility Name (If not institution, give street and number): 314 Whitney Court
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 537-60-8249
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1921
9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 314 Whitney Court
10f. Zip Code: 21078
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: Korean

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Heating & Cooling

17. Father's Neme (First, Middle, Last): Ju Tae Park
18. Mother's Name (First, Middle, Meiden Surneme): Kum Soon Ko

19a. Informant's Name/Relationship (Type, Print): Kyung Park (Spouse)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 Whitney Ct., Havre de Grace, MD 21078

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns. Date: 1/16/01
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA
Due to (or as a consequence of): b. CEREBROVASCULAR ACCIDENT
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. BRAIN CANCER
Due to (or as a consequence of): d.

Part ii. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was case reiirred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Hisup Kim MD
29c. License number: D4642
29d. Date signed (Month, Day, Year): 1/13/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hisup Kim 319 S. UNION AVE Aldo MD 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02161

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CAROL ELIZABETH POSTICH

2. Date of Death — Month: JAN Day: 10 Year: 2001

3. Time of Death: 04=18AM

4a. Facility Name *(If not institution, give street and number)*: ER HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: HAVRE DE GRACE

4c. County of Death: ~~HARFORD~~

Funeral Director

5. Social Security Number: 080-52-4417

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 10/09/1948

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 515 Warren St. Apt. 2

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 0 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disabled

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: Matthew Joseph Postich

18. Mother's Name *(First, Middle, Maiden Surname)*: Barbara Magdalena Schwebius

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Postich- Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 515 Warren St., Apt. 2, Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Erin Cemetery

Date: 1/15/01

20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: Barbara M. Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DOWNS SYNDROME

SEVERE MENTAL RETARDATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: OME

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: JAN 10 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPRABTHU MD T28 BELAIR MD BELAIR MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

POSTICH, CAROL - 1/10/01 - 0418

2

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02162

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harry Boston Palmer, Jr.

2. Date of Death Month Day Year: January 19, 2001

3. Time of Death: 8:25 AM

4a. Facility Name *(If not institution, give street and number)*: 11936 Scaggsville Road

4b. City, Town, or Location of Death: Fulton

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-32-4986

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 3, 1937

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Fulton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 11936 Scaggsville Road

10f. Zip Code: 20759

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 | College (1-4or 5+): Ø

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Harry B. Palmer

18. Mother's Name *(First, Middle, Maiden Surname)*: Vera Catherine Elliott

19a. Informent's Name/Relationship *(Type, Print)*: Sherry Mannas/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12902 Poppyseed Court, Germantown, MD 20874

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Emmanuel UM Church Cem.

Date: 1/23/01

20c. Location - City or Town, State: Scaggsville, MD

21. Signature of Funeral Service Licensee: Janice Rader MO1103

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Md 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Cancer to the Brain — 4months

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicholas Int-Routledge MD

29c. License number: D38509

29d. Date signed *(Month, Day, Year)*: January 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NICHOLAS Int-Routledge 11065 Little Patuxent Pky Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

cof

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02163

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PENN QUARLES

2. Date of Death (Month, Day, Year): JAN 20 2001

3. Time of Death: 0020 AM

4e. Facility Name *(If not institution, give street and number)*: Malcolm Grove Medical Center

4b. City, Town, or Location of Death: Temple Hill

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 578-28-7925

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12 15 1913

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Temple Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5302 Keppler Road

10f. Zip Code: 20748

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Pennick Poindexter

18. Mother's Name *(First, Middle, Maiden Surname)*: Priscilla Jones

19a. Informant's Name/Relationship *(Type, Print)*: Otelia Quarles - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5302 Keppler Road - Temple Hill, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Grove Baptist Church Cem. | Date: 01-25-01

20c. Location - City or Town, State: Orange, VA

21. Signature of Funeral Service Licensee: John E. Thomasson

22. Name and Address of Facility: Thomasson's Funeral Service, Inc. P.O. Box 512 - Louisa, VA 23093-0512

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Kase

29c. License number: D43750

29d. Date signed *(Month, Day, Year)*: JAN. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HENRY OSEI 6104 OLD BRANCH AVE TEMPLE HILL MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: Jeanne B Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

CPS
01-0367-033
MICHAEL POLANSKY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02164

AMENDED# 23a,b,ptII,&27 per ME G793 031301 SS

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael B. Polansky
2. Date of Death Month Day Year: January 22, 2001
3. Time of Death: 16:30
4a. Facility Name *(If not institution, give street and number)*: 9102 Spring Hill Lane #104
4b. City, Town, or Location of Death: Greenbelt
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216-82-8681
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 6,1959
9. Birthplace *(State or Foreign Country)*: Washington,DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Greenbelt
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9102 Spring Hill Lane #104
10f. Zip Code: 20770
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plumber Salesman
16b. Kind of Business/Industry: Plumbing

17. Father's Name *(First, Middle, Last)*: Howard B. Polansky
18. Mother's Name *(First, Middle, Maiden Surname)*: Jeanette G. Luftig

19a. Informant's Name/Relationship *(Type, Print)*: Howard and Jeanette Polansky Parents
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1520 Old Plum Point Rd. Huntingtown, MD. 20639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Lebanon Cemetery
Date: 1/26/01
20c. Location - City or Town, State: Adelphi, MD.

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
b. HYPERTROPHIC CARDIOMYOPATHY

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MORBID OBESITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* scene

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chutenas
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chutenas 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE EMMA ROBINSON
2. Date of Death (Month, Day, Year): Jan. 4, 2001
3. Time of Death: 12:00 AM
4a. Facility Name (If not institution, give street and number): Forest Haven Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-07-0074
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/6/1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5220 York Road
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Russell Cheezum
18. Mother's Name (First, Middle, Maiden Surname): Emma Chadwick

19a. Informant's Name/Relationship (Type, Print): Jo-Ann Beggen /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 205 Jarrettsville, Md. 21084

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Jarrettsville Cem. — Date: 1/8 2001
20c. Location - City or Town, State: Jarrettsville, Md.

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III
22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: PARKINSONS DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tasneem Lakhani
29c. License number: D28595
29d. Date signed (Month, Day, Year): Jan. 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI 7220 Park Heights Ave. Baltimore, Md. 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02166

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CAROLINE M. RANOIA

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 1539

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 163-09-5384

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 2, 1907

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: New Jersey

10b. County: Camden

10c. City, Town or Location: Glendora

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9 Randy Road

10f. Zip Code: 08029

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph (nmn) Nocito

18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa (nmn) Felice

19a. Informant's Name/Reletionship *(Type, Print)*: Philomena V. Centrone / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9 Randy Road, Glendora, NJ 08029

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☒ Other *(Specify)*: Entombment

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harleigh Cemetery Maus. | Date: 1-18-01

20c. Location - City or Town, State: Camden, New Jersey

21. Signature of Funeral Service Licensee: Charles A. Emge Jr.

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Anterior wall myocardial infarction	2 DAYS
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Coronary artery disease	10 years
Due to (or as a consequenca of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Michael Norman Dressner, MD

29c. License number: D32288

29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 520 Upper Chesapeake Drive, Bel Air, Maryland 21014

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

RANOIA, CAROLINE

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH VIRGINIA SHOCKLEY

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 1315

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-16-8636

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 21, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6668 Snow Hill Rd.

10f. Zip Code: 21863

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): William Townsend

18. Mother's Name (First, Middle, Maiden Surname): Pearl Smullen

19a. Informant's Name/Relationship (Type, Print): John W. Shockley/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6668 Snow Hill Rd., Snow Hill, MD 21863

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olive Church Cemetery

Date: 1/14/01

20c. Location - City or Town, State: Snow Hill, MD

21. Signature of Funeral Service Licensee: Keith R Downey CFSP

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardio pulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. septic shock

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ramesh Agarwal M.D.

29c. License number: D54807

29d. Date signed (Month, Day, Year): JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Agarwal, M.D. 1315 S. DIVISION ST. SALISBURY, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Penelope B. Parker

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

215-16-8636

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Ruth V. Shockley

4DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARTWELL DEATON SMITH
2. Date of Death: Month 1 Day 15 Year 2001
3. Time of Death: 2230
4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 578-30-6444
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-25-28
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 14005 NORTH OCEAN ROAD
10f. Zip Code: 21842
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BRICK MASON
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): WILBUR SMITH
18. Mother's Name (First, Middle, Maiden Surname): BERTHA

19a. Informant's Name/Relationship (Type, Print): ROBERT & RICK SMITH / SONS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 KINGSWAY DR. GAMBRILLS, MD. 21054

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): SALISBURY CREMATORY
Date: 1-19
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020 Exp 11/5/01 2230

Hartwell Smith DOB 6/25/28 578-30-6444

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIOGENIC SHOCK
Due to (or as a consequence of):
b. ISCHEMIC CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] B. VanVoorhees
29c. License number: D0065906
29d. Date signed (Month, Day, Year): 01/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUCY B. VAN VOORHEES, 314 FRANKLIN AVE., BERLIN, MD

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02169

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Ann Sheppard
2. Date of Death Month Day Year: January 8, 2001
3. Time of Death: 2:20 PM
4a. Facility Name *(If not institution, give street and number)*: Heart Homes
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-26-4882
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 11, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 108 Kingbrook Road
10f. Zip Code: 21090
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Scott Franklin Little
18. Mother's Name *(First, Middle, Maiden Surname)*: Frances (u/k) Singleton

19a. Informant's Name/Relationship *(Type, Print)*: Jean Walker / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 108 Kingbrook Road, Linthicum, MD 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion U.M. Cemetery
Date: 1-12-01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emge
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metabolic Acidosis
Due to (or as a consequence of):
b. Cardiopulmonary Arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Dehydration
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Doreen Pieri, MD
29c. License number: D44377
29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Doreen Pieri, MD 6320 Ritchie Highway Suite 1 Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA A. STACK

2. Date of Death: Month JAN Day 22 Year 2001

3. Time of Death: 1445

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 220-24-9366

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 18, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10063 Windstream Drive

10f. Zip Code: 21044

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: C & P Telephone

17. Father's Name (First, Middle, Last): George Tyrrell

18. Mother's Neme (First, Middle, Maiden Surname): Jennie Tatum

19a. Informent's Neme/Reletionship (Type, Print): Joseph Stack / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10063 Windstream Dr. Columbia, MD. 21044

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Columbia Memorial Park

Dete: Jan. 26 2001

20c. Location - City or Town, Stete: Columbia, Maryland

21. Signature of Funerel Servica Licensee: [signature] MD1096

22. Neme end Address of Fecility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)

a. PULMONARY FIBROSIS — 7 YEARS

Due to (or es e consequence of):

b. ARDS — 7 YEARS

Sequentially list conditions, if sny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last

Due to (or es e consequence of):

c. —

Due to (or es a consequenca of):

d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: TRACHEOMALACIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion snd/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] MD

29c. License number: D0018317

29d. Date signed (Month, Day, Year): JAN 22 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): BERNARD P. FARRELL MD 11055 LITTLE PATUXENT PKWY. COLUMBIA, MD 21044

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

dec 15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth A. Shoals
2. Date of Death (Month, Day, Year): January 22 2001
3. Time of Death: 7:00 am
4a. Facility Name (If not institution, give street and number): Autumn Hill Assisted Living
4b. City, Town, or Location of Death: Highland
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212 12 0718
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11913 New Country Lane
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Leonard B. Anderson
18. Mother's Name (First, Middle, Maiden Surname): Anna F. Anderson

19a. Informant's Name/Relationship (Type, Print): William B. Shoals/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11913 Country Lane Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: Jan. 24 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature] 1/01/01
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) asst living

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 51360
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN FISH MD 3460 ELLICOTT CTR DR #103 ELLICOTT CITY MD 21043

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02172

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Schwartz
2. Date of Death Month Day Year: January 23, 2001
3. Time of Death: 4:45 pm
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 174-05-9192
6. Sex: 1☐M 2☐F XX
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 26, 1919
9. Birthplace *(State or Foreign Country)*: Pennsylvannia

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1XXYes 2☐No
10e. Street and Number: 104 Sharon Court #103
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2XXMarried 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2XXNo If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2XXNo Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Grade 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman (shoe)
16b. Kind of Business/Industry: retail

17. Father's Name *(First, Middle, Last)*: Paul Schwartz
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Winfield

19a. Informant's Name/Relationship *(Type, Print)*: Jo E. Schwartz / spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 104 Sharon Court #103 Laurel, Maryland 20707

20a. Method of Disposition: 1☐Burial 2XXCremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: Jan 25, 2001
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature] /M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. cardiopulmonary arrest — minutes
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. dilated cardiomyopathy — years
Due to (or as a consequence of):
c. Hypertension — years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
end-stage renal disease
multi-infarct dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2XXNo 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2XXNo
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes XXNo

25. Was case referred to medical examiner? 1☐Yes XXNo

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2XXER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: XXNatural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Angela Duncan MD
29c. License number: D43575
29d. Date signed *(Month, Day, Year)*: January 25, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Angela Duncan, MD 7350 Van Dusen Road Laurel, Maryland 20707

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SALLY EMILY STARKEY

2. Date of Death: Month JAN. Day 11 Year 2001

3. Time of Death: 10:22 AM

4a. Facility Name (If not institution, give street and number): CORSICA HILLS NURSING HOME

4b. City, Town, or Location of Death: CENTREVILLE

4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 213-22-8133

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 9, 1907

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE'S

10c. City, Town or Location: CENTREVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 113 GLENDALE AVENUE

10f. Zip Code: 21617

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 5 | College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FACTORY WORKER

16b. Kind of Business/Industry: DEFENSE PLANT

17. Father's Name (First, Middle, Last): ABRAHAM LORD

18. Mother's Name (First, Middle, Maiden Surname): MARY PINDER

19a. Informant's Name/Relationship (Type, Print): GEORGE S. STARKEY, JR./ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 113 GLENDALE AVENUE, CENTREVILLE, MD 21617

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHESTERFIELD CEMETERY

Date: 1-13-2001

20c. Location - City or Town, State: CENTREVILLE, MD

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric R. Ciganek M.D.

29c. License number: D35048

29d. Date Signed (Month, Day, Year): 1/11/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ERIC R. CIGANEK, M.D., 2540 CENTREVILLE ROAD, CENTREVILLE, MD 21617

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene D. Truitt

2. Date of Death: Month: January Day: 10 Year: 2001

3. Time of Death: 1508

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 043-01-7975

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/25/1918

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 200 Hantwerker Drive

10f. Zip Code: 19940

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician

16b. Kind of Business/Industry: Beauty Shop

17. Father's Name (First, Middle, Last): McCready Dickerson

18. Mother's Name (First, Middle, Maiden Surname): Sadie B. Bradley

19a. Informant's Name/Relationship (Type, Print): Charles M. Truitt Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Hantwerker Drive, Delmar, DE 19940

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stephens Cemetery

Date: 1/13/2001

20c. Location - City or Town, State: Delmar, Delaware

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: 13 E. Grove Street Short Funeral Home Delmar, DE 19940

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 054807

29d. Date signed (Month, Day, Year): 1-10-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Agarwal, M.D. 100 E. Carroll St. Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Irene Truitt

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02175

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Calvin Coolidge Taylor
2. Date of Deeth: Month Jan. Day 06 Year 2001
3. Time of Deeth: 0550
4a. Facility Neme (If not institution, give street and number): Penisula Regional Medical Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 227-24-0940
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 76 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 11/04/1924
9. Birthpiece (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. State: Virginia
10b. County: Accomack
10c. City, Town or Location: Atlantic
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10457 Smith Rd.
10f. Zip Code: 23303
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 1st; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Neme (First, Middle, Last): Cammie Taylor
18. Mother's Neme (First, Middle, Meiden Surneme): Everlena Wharton

19a. Informent's Neme/Reletionship (Type, Print): Nettie Brown Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): P. O. Box 52, Assawoman, VA 23302

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Taylor Family Cemetery
Date: 01/13/01
20c. Location - City or Town, Stete: Atlantic, VA

21. Signature of Funeral Service Licensee: Samuel D. Cooper Jr.
22. Name and Address of Facility: Cooper & Rumbles Funeral Co., INC. Accomac, VA 23301

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximete Interval Between Onset end Death)

Immediete Ceuse (Finel diseese or condition resulting in deeth):
a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequenca of):
b.
Due to (or es a consequenca of):
c.
Due to (or as a consequance of):
d.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cirrhosis of Liver
Hepatitis C.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings aveilable prior to completion of cause of death? N/A 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Mahesh Mundra
29c. License number: D32014
29d. Date signed (Month, Day, Year): 1/12/01

30. Name and eddress of person who completed cause of death (Item 23e) (Type. Print): MAHESH MUNDRA 106 MIFORD ST SUIT B SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signeture: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02176

TARTLER, Agnes

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes TARTLER
2. Date of Death: Month JANUARY Day 22 Year 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: None

Funeral Director

5. Social Security Number: 174 03 3899
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 30, 1907
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6336 Cedar Lane Apt 328
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Frank Wintruba
18. Mother's Name (First, Middle, Maiden Surname): Anna Gustashaw

19a. Informant's Name/Relationship (Type, Print): Agnes M. Halsor/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10253 Bristol Channel Ellicott City, MD 21042

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery — Date: 1-24-2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Shawn a Collins-Witzke MO1044
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's disease — Years

Due to (or as a consequence of):
b. Depression — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Dehydration — 1 week

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day, Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D0055391
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ming Yi, 210 Business Center Drive, Reisterstown, Maryland, 21136

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

dec 4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02177

NAME KNOWN TO PHYSICIAN: TRAGESER, JOHN

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John L. Trageser
2. Date of Death (Month, Day, Year): JANUARY 10, 2001
3. Time of Death: 10:40 PM
4e. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 216-16-8868
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3209 E. Bend Court
10f. Zip Code: 21009
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tradesman
16b. Kind of Business/Industry: City Government

17. Father's Name (First, Middle, Last): George Trageser
18. Mother's Name (First, Middle, Maiden Surname): Elsie O'Toole

19a. Informant's Name/Relationship (Type, Print): Patricia A. Trageser (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3209 E. Bend Court, Abingdon, Maryland 21009

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Mem. Gardens Maus
Date: 1/13/01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd., Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CANCER OF PROSTATE	UNKNOWN
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D16608
29d. Date signed (Month, Day, Year): JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KAM KEN LEUNG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02178

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY HELEN USILTON
2. Date of Death Month Day Year: Jan. 04, 2001
3. Time of Death: 11:00 AM
4a. Facility Name *(If not institution, give street and number)*: 1744 Hope Road
4b. City, Town, or Location of Death: Centreville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 219-34-3205
8. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 9, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 104Tilghman Avenue
10f. Zip Code: 21617
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 9; College (1-4or 5+): -0-
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Self

17. Father's Name *(First, Middle, Last)*: William Henry Moore
18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Helen Hall

19a. Informant's Name/Relationship *(Type, Print)*: M. Rebecca Chance/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1744 Hope Rd., Centreville, Md. 21617

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Chesterfield Cemetery
Date: Jan. 8, 2001
20c. Location - City or Town, Stete: Centreville, Md.

21. Signeture of Funerel Service Licensee: W. M. Helfenbein
22. Name and Address of Feciility: Fellows, Helfenbein & Newnam Funeral HOme 408 S. Liberty St., Centreville, Md.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): e. metastatic colon CA — year

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease
cerebrovascular insufficiency
diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred te medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's Residence

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Kathleen Hoey
29c. License number: D47627
29d. Dete signed *(Month, Day, Year)*: 1-09-01

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Kathleen Hoey, M.D., 207 N. Liberty St., Centreville, Md. 21617

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02179

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leonard Richard VanSaders

2. Date of Death Month Day Year: Janaury 13, 2001

3. Time of Death: 7:40 A.M.

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 135-12-3323

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1919

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 419 Woodcrest Drive

10f. Zip Code: 21001

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Service

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Richard VanSaders

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Zarubnicky

19a. Informant's Name/Relationship *(Type, Print)*: Marie A. VanSaders (Spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 419 Woodcrest Dr., Aberdeen, Maryland 21001

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: R. A. Ferris & Co., Inc.

Date: 1/15/01

20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. dilated cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

severe obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Eck MD

29c. License number: D31712

29d. Date signed *(Month, Day, Year)*: 1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECK JR 219 W. BELAIR AVE. ABERDEEN, MD 21001

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: B. Ayers

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

VANSADERS, Leonard R. BV

January 13, 2001 T.O.D. 7:40 AM Dr Eck

10

DHMH 16 Rev 6/95

ORIGINAL

JAN 1 8 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02180

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTHA WRIGHT
2. Date of Death — Month: JANUARY Day: 6 Year: 2001
3. Time of Death: 12:18 PM
4a. Facility Name (If not institution, give street and number): DEER'S HEAD CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-28-4926
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 26, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 27390 Log Cabin Road
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Peninsula Regional Medical Center

17. Father's Name (First, Middle, Last): Robert Wallace, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Roszina Carter

19a. Interment's Name/Relationship (Type, Print): Mr. Allen Wright, Sr./husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27390 Log Cabin Road - Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): John Wesley Church Cem. — Date: 1/13/01
20c. Location - City or Town, State: Deal Island, Maryland

21. Signature of Funeral Service Licensee: Allen Jolley
22. Name and Address of Facility: 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SCLERODERMA — >4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Virginia A Dulany MD CME
29c. License number: D33905
29d. Date signed (Month, Day, Year): January 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA A DULANY MD CME PO Box 298 SALISBURY Md 21802-2018

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: Donna G. Sparks

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ann Theresa Wimmer
2. Date of Death: Month January, Day 14, Year 2001
3. Time of Death: 1:42 AM
4a. Facility Name (If not institution, give street and number): 804 Falconer Road
4b. City, Town, or Location of Death: Joppa
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 179-38-0774
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb. 27, 1948
9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 804 Falconer Road
10f. Zip Code: 21085
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner / Operator
16b. Kind of Business/Industry: Beauty & Tanning Salon
17. Father's Name (First, Middle, Last): Howard (u/k) Reinhard
18. Mother's Name (First, Middle, Maiden Surname): Mary (u/k) Albano
19a. Informant's Name/Relationship (Type, Print): Fred Wimmer / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Falconer Road, Joppa, Maryland 21085
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Joseph's Cemetery
Date: 1-16-01
20c. Location - City or Town, State: Fullerton, Maryland
21. Signature of Funeral Service Licensee: Charles A. Emge
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. NON SMALL CELL LUNG CANCER WITH BRAIN METS — SEVEN MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Sein Aung
29c. License number: D51555
29d. Date signed (Month, Day, Year): 01/15/2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SEIN AUNG, 2021 B EMMORTON ROAD, SUITE 212, Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL ALAN WORKMAN
2. Date of Death (Month, Day, Year): January 8, 2001
3. Time of Death: 1:53 PM
4a. Facility Name (If not institution, give street and number): In woods off Shavox Road
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 215-72-3538
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 40 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4, 1960
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Parsonsburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 32362 Longridge Road
10f. Zip Code: 21849
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Auto Body

17. Father's Name (First, Middle, Last): Charles L. Workman
18. Mother's Name (First, Middle, Maiden Surname): Aline V. Morris

19a. Informant's Name/Relationship (Type, Print): Charles L. Workman/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32362 Longridge Rd., Parsonsburg, MD 21849

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 1/11/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Keith R Downey CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Gunshot wound to chest — NA
Due to (or as a consequence of):
Self inflicted

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Forest
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 1/9/01
28b. Time of Injury: UKN M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Gunshot wound to chest
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Shavox Road, Parsonsburg woods
28f. Location (Street and Number or Rural Route Number, City or Town, State): Forest / PARK

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D.O. DME
29c. License number: H50497
29d. Date signed (Month, Day, Year): 1/11/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. CHRISTOPHER SNYDER 106 Milford St, Salisbury, MD 21804 410-749-7284

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Penny G. Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RJD
LAURA WHITE
01-338-033

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Berniece White
2. Date of Death: Month JANUARY Day 20, Year 2001
3. Time of Death: 2110 P.M.
4a. Facility Name (If not institution, give street and number): 121 SECOND STREET#3
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-32-8595
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 4, 1935
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 121 Second Street #3
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Emery Johnson
18. Mother's Name (First, Middle, Maiden Surname): Maude Johnson

19a. Informant's Name/Relationship (Type, Print): Georgetta Speigle / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Dell Place Laurel, Maryland 20707

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: Jan. 25, 2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Gary S. Kyle /M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. Laurel, Maryland 20707

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Subarachnoid Hemorrhage
Due to (or as a consequence of):
b. Ruptured Cerebral Artery Aneurysm

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify): SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Putnam, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(4)

Cpff

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02184

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace Austin

2. Date of Death Month: 01 Day: 26 Year: 2001

3. Time of Death: 11:30 AM

4a. Facility Name *(If not institution, give street and number)*: 3310 Benson Avenue #307

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-8525

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct.31,1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3310 Benson Avenue #307

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:

13. Wes Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: apartment manager

16b. Kind of Business/Industry: housing

17. Father's Neme *(First, Middle, Last)*: Alexander Watson

18. Mother's Neme *(First, Middle, Maiden Sumema)*: Mary G. Starkey

19a. Informent's Name/Relationship *(Type, Print)*: Ronald Tarbert - nephew

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 403 Barclay Court, Altamonte Springs, FL 32701

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stale 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or othar piece)*: Greenmount Cemetery

Date: 1/31/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann G. Zink

22. Neme and Addrass of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Causa (Final diseese or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streal, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: MD

29c. License number: D0025544

29d. Date signed *(Month, Day, Year)*: 01-27-01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTINE COMMERFORD, MD 5411 OLD FREDERICK RD #18 BALTIMORE, MD 21229

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signatura: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRIEDA MAY OHRMANN ADAMS

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 6:35AM

4a. Facility Name (If not institution, give street and number): Manorcare Towson Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 216-03-0535

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 29, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3019 Woodside Avenue

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing Manufacturer

17. Father's Name (First, Middle, Last): Herman Karl Ohrmann

18. Mother's Name (First, Middle, Maiden Surname): Charlotte Marguerita Lohmeyer

19a. Informant's Name/Relationship (Type, Print): Elsa M. Hohne (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3019 Woodside Avenue, Baltimore, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 2/1/2001

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Martin D. Lawson

Martin D. Lawson

22. Name and Address of Facility: Altenburg Funeral Home, P.A. 6009 Harford Road, Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DISEASE

SPINAL STENOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D24100

29d. Date signed (Month, Day, Year): 01-30-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MADURA L. PRABHAKAR M.D 300 ARMORY PLACE BAL MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Dawn B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02186

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joyce Anderson

2. Date of Death — Month: January Day: 27 Year: 2001

3. Time of Death: 7:50 PM

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 140-32-2095

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 7-14-1941

9. Birthplace *(State or Foreign Country)*: N.J.

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 50 W. Biddle Street

10f. Zip Code: 21202

10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 11th grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurses Aide

16b. Kind of Business/Industry: Nursing Home

17. Father's Name *(First, Middle, Last)*: Eddie Wise

18. Mother's Name *(First, Middle, Maiden Surname)*: Vernell Truesdale

19a. Informant's Name/Ratationship *(Type, Print)*: Kevin Anderson - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 50 W. Preston Street Baltimore, Md 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fairlawn Cemetery

Date: 2-2-2001

20c. Location - City or Town, State: Fairlawn, N. Y.

21. Signature of Funeral Service Licensee: Dale March

22. Name and Address of Facility: March West F/H 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. colon carcinoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Linda George M.D.

29c. License number: P14569

29d. Date signed *(Month, Day, Year)*: January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda George MD, c/o Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Leonard B Kaye

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Joyce Anderson

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IMOGENE F. ANTHONY
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 08:10
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 217-26-2286
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 8, 1931
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: LARNEY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3232 SUMMIT AVE.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARIAL
16b. Kind of Business/Industry: WATER + HEATING CO.

17. Father's Name (First, Middle, Last): JOHN GREY
18. Mother's Name (First, Middle, Maiden Surname): IMOGENE

19a. Informant's Name/Relationship (Type, Print): ROBERT E. ANTHONY, SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3232 SUMMIT AVE. LARNEY, MARYLAND 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: JAN. 27 2001
20c. Location - City or Town, State: PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pulmonary embolus — 1 day
Due to (or as a consequence of):
b. Small cell lung cancer — 3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: 98028
29d. Date signed (Month, Day, Year): JANUARY 24, 2001
30. Name and address of person who completed cause of death (item 23a) (Type, Print): A. HERZBRUCH M.D. JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 Eastern Ave, BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month Day Year	3. Time of Death
MORRIS	ALPERSTEIN	JANUARY 24, 2001	4:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3641 GLENGYLE AVENUE #C-4	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	If Under 1 Yaar: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (State or Foreign Country)
217-07-3022	XX 1 M 2 F	88 Yrs.					OCT. 7, 1912	MD

Usual Residence of Dacedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	XX 1 Yas 2 No

10e. Streat and Number	10f. Zip Coda	10g. Citizen of What Country?
3641 GLENGYLE AVENUE #C-4	21215	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, White, atc.
1 Nevar Married 2 X Married 3 Widowed 4 Divorced	1 Yas 2 XX No If Yas, Giva Yaar or Datas:	1 Yas 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highast grada complatad)		16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
	5+	RETAIL MERCHANT	FURNITURE

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middle, Maidan Surnama)
MAX ALPERSTEIN	FANNIE FUHRMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
EDITH ALPERSTEIN / WIFE	3641 GLENGYLE AVENUE #C-4 - BALTIMORE, MD 21215

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cematary, crematory or othar placa)	Data	20c. Location - City or Town, Stata
X 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify)	BETH JACOB CEMETERY	1/26/01	FINKSBURG, MD

21. Signatura of Funaral Sarvica Licansaa	22. Nama and Addrass of Facility
Scott M. Cuttler	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediata Cause (Finel disaesa or condition resulting in death)
a. CA OF ESOPHAGUS — ± 4 YRS

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last
b.

Dua to (or as a consequance of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

ISCHEMIC CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings svailable prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was casa rafarrad to medical exeminer?	26. Placa of Death (Check only one)	
1 Yas 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Homa 5 X Rasidance 6 Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicida 4 Homicida 5 Pending Invastigation 6 Could not be determined		M	1 Yas 2 No	

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to the causa(s) and mannar as stated.
2 **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and dua to the cause(s) and mannar statad.

29b. Signatura and title of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
Raymond F. Carlon M.D.	D-04601	1/25/01

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print)
RAYMOND F. CARLON M.D.

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
JAN 30 2001	Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Regina M. Abell
2. Date of Death: Month January, Day 25, Year 2001
3. Time of Death: 9:15 P.M.
4a. Facility Name (If not institution, give street and number): St. Elizabeth Rehabilitation & Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213 26 6578
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec. 9, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3320 Benson Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Ruben & Company Sewing Factory

17. Father's Name (First, Middle, Last): James Francis Abell
18. Mother's Name (First, Middle, Maiden Surname): Marie B. Hill

19a. Informant's Name/Relationship (Type, Print): Ann L. Doelle / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 Charles Road Linthicum, Maryland 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 1/27/01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Donna M Zaremowski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE MYOCARDIAL INFARCTION	2 MINUTES
Due to (or as a consequence of): b.	CORONARY HEART DISEASE	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	GENERALIZED ATHEROSCLEROSIS	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: NON-INSULIN Dependent Diabetes. STROKE WITH RIGHT hemiparesis. Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING
29c. License number: D16200
29d. Date signed (Month, Day, Year): JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. N. M. MACHIRAN 720-C MAIDEN Choice LA, CATONSVILLE, 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02190

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY M ARROWOOD
2. Date of Death — Month: JANUARY Day: 25 Year: 2001
3. Time of Death: 7 02 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 241-26-6704
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul. 29, 1920
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: Md
10b. County: BALTIMORE
10c. City, Town or Location: PIKESVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1217 COBB ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): THREAD MACH. OPER.
16b. Kind of Business/Industry: TEXTILE INDUST.

17. Father's Name (First, Middle, Last): MILTON B. PROFFITT
18. Mother's Name (First, Middle, Maiden Surname): DONNA F. RICE

19a. Informant's Name/Relationship (Type, Print): RUFUS D. ARROWOOD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1217 COBB Rd. PIKESVILLE, Md. 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NAT'L CEM. Date: 2/5/01
20c. Location - City or Town, State: VA.

21. Signature of Funeral Service Licensee: Hartley Miller
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 HARFORD Rd. BALTIMORE, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ESRD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C. Ravi MD
29c. License number: D37333
29d. Date signed (Month, Day, Year): JANUARY 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02191

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERMAN BARTHOLME

2. Date of Death — Month: 1 Day: 27 Year: 2001

3. Time of Death: 7:50 AM

4a. Facility Name *(If not institution, give street and number)*: Future Care at Homewood

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-28-4900

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 21, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1800 Hollins Street Apt 326 West

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Transportation

17. Father's Name *(First, Middle, Last)*: Herman Joseph Bartholme

18. Mother's Name *(First, Middle, Maiden Surname)*: Hedwig Binder

19a. Informant's Name/Relationship *(Type, Print)*: Melvin Bartholme/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3344 Keswick Road Baltimore, MD 21211

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 1-29-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn McDonald

Dawn McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes; HTN Renal Failure; Neurosyphilis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D. Sologa

29c. License number: D17537

29d. Date signed *(Month, Day, Year)*: 1-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARSHAN S. SALUJA MD 1600 W. Mount Royal Ave, Balto 21217

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02192

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin Brukiewa
2. Date of Death (Month, Day, Year): JANUARY 27 2001
3. Time of Death: 8:15 Pm
4a. Facility Name (If not institution, give street end number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 217-34-4709
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/ 12/ 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2807 Fait Ave.
10f. Zip Code: 21224
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1955-75
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military Policeman
16b. Kind of Business/Industry: United States Army

17. Father's Name (First, Middle, Last): Michael Brukiewa
18. Mother's Name (First, Middle, Maiden Surname): Genevieve Gos

19a. Informant's Neme/Relationship (Type, Print): Mary O. Brukiewa Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2807 Fait Ave. Baltimore, Maryland 21224

20a. Method of Disposition: 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Holly Hills Memorial
Date: 01/31/01
20c. Location - City or Town, State: Baltimore Maryland

21. Signeture of Funerel Service Licensee: David J. Weber CFSP
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Cirrhosis — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier: Ron Elfenbein MD
29c. License number: RES-000
29d. Date signed (Month, Dey, Year): January 27, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Ron Elfenbein Johns Hopkins Hospital - 600 N. Wolfe St. Baltimore MD

State Registrar

31. Dete filed (Month, Day, Year): JAN 3 0 2001
32. Registrar's Signature: Jenna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02193

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IDA BALDERAS

2. Date of Death — Month: January Day: 27 Year: 2001

3. Time of Death: 16:00

4a. Facility Name *(If not Institution, give street end number)*: The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-64-6226

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 46 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: August 3, 1954

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 338 Gatewater Court #102

10f. Zip Code: 21060

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: home

17. Father's Name *(First, Middle, Last)*: Lee Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Lottie Mae Smith

19a. Informant's Name/Relationship *(Type, Print)*: Anthony S. Balderas - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 110 Janelin Drive, Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Glen Haven Cemetery

Date: 2/2/01

20c. Location - City or Town, State: Brooklyn Park, MD

21. Signature of Funeral Service Licensee: ▶ Ann Y. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. arrhythmia — 20min

Due to (or as a consequance of):

b. myocardial infarction — 10days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. coronary artery disease — 10 yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cecilia Park, Johns Hopkins Hospital, 600 N. Wolfe St Baltimore, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02194

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma Anna Bailey
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 1200pm
4a. Facility Name *(If not institution, give street and number)*: Franklin Woods
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-38-0204
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12-29-1912
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8636 Winding Way
10f. Zip Code: 21128
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home maker
16b. Kind of Business/Industry: In own home

17. Father's Name *(First, Middle, Last)*: Gustuv Ricko
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Dora

19a. Informant's Name/Relationship *(Type, Print)*: daughter Emily Bailey Schneeman
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8636 Winding Way, Perry Hall, Maryland 21128

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn
Date: 1/31/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Joseph N. Zannino Jr.
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm, 263 S. Conkling St., Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	End Stage Dementia	2 years
Due to (or as a consequence of): b.	Cerebro vesculor Accident	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hypertension	10 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Lee MD
29c. License number: D53462
29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jude Muneses, MD 7845 Oakwood Road Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

01-0403-510
CJ
Robert W. Barno

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #17 per inf G793 032301 SS
AMEND# 23,27&28a-f G793 030901 SS

Certificate of Death

Reg. No. 2001 02195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT W. BARNO
2. Date of Death: Month January, Day 24, Year 2001
3. Time of Death: 08:36 P.M.
4a. Facility Name (If not institution, give street and number): University of Maryland, Shock Trauma
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 224-40-7084
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 10 10 37
9. Birthplace (State or Foreign Country): VIRGINA

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1824 PRESSTMAN ST.
10f. Zip Code: 21217
10g. Citizen of What Country?: US

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ H; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAREHOUSE
16b. Kind of Business/Industry: PACKING INDUSTRY

17. Father's Name (First, Middle, Last): ~~ROBERT W BARNES~~ Robert W. Barno
18. Mother's Name (First, Middle, Maiden Surname): CARRIE BOYD

19a. Informant's Name/Relationship (Type, Print): ROBERTA B. STAPLES
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2201 ROLLINS DR ALEXANDRIA, VA 22307

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NORTHERN VIRGINA CREMATION
Date: 01/30/01
20c. Location - City or Town, State: ARLINGTON VA.

21. Signature of Funeral Service Licensee: Philip Bell
22. Name and Address of Facility: PHILIP BELL FUNERAL SERVICE TEMPLE HILLS 4902 STAN HAVEN RD 20748 MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES WITH COMPLICATIONS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide ~~5 ☒ Pending investigation~~ 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 1-2-01
28b. Time of Injury: 7:50 AM
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject pedestrian struck by train
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): railroad tracks
28f. Location (Street and Number or Rural Route Number, City or Town, State): Light Rail Station 320 W. North Ave., Balto., MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02196

Father known as Raymond Banks

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond V. Banks Sr.

2. Date of Death: Month January Day 25 Year 2001

3. Time of Death: 5:45 a.m

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 213-52-1733

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06 07 50

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3748 Columbus Drive

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married [XX] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [XX] No Specify:

14. Reca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Rouse Company

17. Father's Name (First, Middle, Last): Raymond Hawkins

18. Mother's Name (First, Middle, Maiden Surname): Ertie Williams

19a. Informant's Name/Relationship (Type, Print): Yvonne Banks-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3748 Columbus Drive, Baltimore Md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): King Memorial Park

Date: 2/1/01

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Thomas B. Keke

22. Neme end Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai diseese or condition resulting in deeth)

a. Pneumonia — 2 days

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung Cancer — 10 years

Due to (or as a consequence of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: Raj R Doshi MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajiv R Doshi MD Sinai Hospital of Baltimore 2401 W. Belvedere Avenue Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification:

01-0369-510
LRB
PEARLIE BLUE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,b,27,& 28a-f per phys G792 022301 — *Certificate of Death*

Reg. No. 2001 02197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Pearly	Stanley	Blue Jr.	January 22, 2001	9:35 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bon Secours Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-28-9761	XX 1☐M 2☐F	68 Yrs.			02 22 32	V.A.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2611 North Hilton Street	21216	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Fork Lift Operator	Freight Corporation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Pearly Stanley Blue Sr.	Lillie Lyell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alma Gray-Sister	8453 Gold Sunset Way, Columbia, Md 21045

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Garrison Forest Vet.	1/31/01	Owings Mills, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Harry L. Hagan	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE COCAINE INTOXICATION ASSOCIATED WITH CARDIAC HYPERTROPHY DILATATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPERTENSIVE CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☒Pending investigation 6☒Could not be determined	found: 1-22-01	found: 8:47 PM	1☐Yes 2☒No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found at home	2611 N. Hilton St., Balto., MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Dennis J. Chutenko	O.C.M.E.	January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutenko 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 30 2001	Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

01-0379-510

LINWOOD BROCK
ASP

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02198

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Linwood Brock

2. Date of Death Month / Day / Year: JANUARY 23 2001

3. Time of Death: 11:25 A

4a. Facility Name *(If not Institution, give street and number)*: 444 MANSE CT.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-64-6761

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 01-04-52

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 444 Manse Court

10f. Zip Code: 21201

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Special Ed. — College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fulltime

16b. Kind of Business/Industry: Sun Pride Rayman Drug District

17. Father's Name *(First, Middle, Last)*: Charles Brock

18. Mother's Name *(First, Middle, Maiden Surname)*: Melvina Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Melvina Dowdy

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4402 Rokeby Road Baltimore, MD. 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens — Date: 01-29-2001 — 20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 W.M.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: JANUARY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Death
John William Benner	January 28, 2001	7:55 A.M.

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
14392 Frederick Road	Cooksville	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
438-03-3155	1 ☒ M 2 ☐ F XX	90 Yrs.			May 7, 1910	Maryland

Usual Residanca of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Howard	Cooksville	1 ☐ Yas 2 ☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
14392 Frederick Road	21723	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1 ☐ Navar Marriad 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorcad	1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highest grade completed)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
8		Head Ticket Checker	Horse Racing Industry

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Neme (First, Middle, Maiden Surname)
John Adam Benner	Claudia Elizabeth Hooper

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Angela Price Niece	14392 Frederick Road; Cooksville, Maryland 21723

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemafary, crematory or other placa)	Data	20c. Location - City or Town, Stata
1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)	New Cathedral Cemetery	1/31/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Joseph J Kellner #000733

22. Nama and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease(s) or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona causa on aach lina.

		Approximate Interval Between Onsat and Death
Immediate Cause (Finel diseese or condition rasulting in death)	a. bladder cancer	12 months
	Due to (or as e consequence of):	
Saquantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in daath) Last	b.	
	Dua to (or as a consaquanca of):	
	c.	
	Dua to (or as a consaquanca of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

chronic obstructive pulmonary disease

coronary artery disease

type 2 diabetes mellitus

23b. Did tobacco use contribute to the causa of death? ☒ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of causa of death?
1 ☐ Yas 2 ☒ No	1 ☐ Yas 2 ☒ No

25. Wes casa rafarrad to medical examiner? 1 ☐ Yas 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA; Othar: 4 ☐ Nursing Homa 5 ☒ Rasidanca 8 ☐ Othar (Specify)

27. Mannar of Daath	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarminad		M	1 ☐ Yes 2 ☐ No	

28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1 ☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at the time, data and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axaminetion and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and title of cartifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶	D52481	January 29 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): David Plotkin M.D. 18111 Prince Philip Drive Suite 304 Olney, MD 20832

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
JAN 30 2001	▶

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02200

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: George C. Brown
2. Data of Death Month Jan Day 29, Yaar 2001
3. Tima of Daath: 2 A M
4a. Facility Nama *(If not institution, giva street and number)*: Union Memorial Hosp.
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Sacurity Numbar: 215-14-8990
6. Sex: XX 1 M 2 F
7. Aga *(In yrs. last birthday)*: 77 Yrs. (If Under 1 Year: Months / Days; If Undar 24 Hrs.: Hours / Min.)
8. Data of Birth *(Month, Day, Yaar)*: July 1, 1923
9. Birthplace *(State or Foraign Country)*: Maryland

Usual Rasidance of Decedent

10a. Stata: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: XX 1 Yas 2 No
10e. Street and Number: 851 West 33rd Street
10f. Zip Coda: 21211
10g. Citizen of What Country?: U.S.A.

11. Marital Statua: 1 Never Married 2 Married XX 3 Widowed 4 Divorced
12. Was Decadant Evar in U.S. Armed Forcas? 1 Yas XX 2 No If Yas, Giva Yaar or Datas:
13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 Yas XX 2 No Specify:
14. Raca - Amarican Indian, Black, Whita, etc. Specify: White
15. Decadant's Education *(Specify only highest grada compiatad)*: Elementary/Sacondary (0-12): 3rd; College (1-4or 5+):
16a. Decadant's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use ratirad)*: Truck Driver
18b. Kind of Business/Industry: Sunpapers
17. Fathar's Nama *(First, Middle, Last)*: George Brown
18. Mother's Neme *(First, Middle, Maidan Sumame)*: Mildred
19a. Informant's Name/Ralationship *(Type, Print)*: Daniel Brown (Son)
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 3920 Elm Avenue Balto, MD 21211
20a. Method of Disposition: 1 Burial 2 XX Cramation 3 Ramoval from Stata 4 Donation 5 Othar *(Specify)*
20b. Place of Disposition *(Nama of camatary, crematory or othar placa)*: Balto-Wash Crematory
Data: 1/30/01
20c. Location - City or Town, Stata: Laurel, MD
21. Signatura of Funaral Sarvica Licansee: Richard Carpenter
22. Nama and Addrass of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Rd. Balto, MD 21211

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart faitura. List only ona causa on aach lina.

Approximate Intarval Batwaan Onset and Death

Immadiata Causa (Finel disaasa or condition resulting in daath)
a. Sepsis — Approximate Intarval: 1 day
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequance of):
d.

IF FEMALE:
23b. Was decadent pregnent in tha past 12 months? 1 Yas 2 No 9 Unknown
23c. If yas, outcoma of pregnancy: 1 Live birth 2 Fatal daath 3 Ectopic pregnancy 4 Pregnant at tima of daath 5 Other *(specify)* 9 Unknown
23d. Date of delivary: Month Day Yaar

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.: Alzheimer's Disease

23e. Did tobacco use contributa to tha causa of daath? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yas 2 No
24b. Were autopsy findings availabla prior to compiation of causa of daath? 1 Yes 2 No
25. Was casa raferrad to medical exeminer? 1 Yas 2 No
26. Placa of Daath *(Chack only ona)*: Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA; Othar: 4 Nursing Homa 5 Residence 6 Othar *(Specify)*
27. Manner of Deeth: 1 Natural 2 Accidant 3 Suicida 4 Homicida 5 Pending investigation 6 Could not ba datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1 Yas 2 No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straet, factory, office building, atc. *(Specify)*
28f. Location *(Street and Numbar or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier *(Check only one)*: 1 **Certifying Physician:** To tha bast of my knowledga, daath occurrad at the time, date and place, and dua to tha causa(s) and mannar as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, data and place, and dua to the causa(s) and mannar stalad.
29b. Signalura and tilta of cartifiar: Richard L Diamond
29c. Licansa numbar: D23076
29d. Data signad *(Month, Day, Yaar)*: 1/29/01
30. Name and addrass of parson who complatad causa of death (Item 23a) (Typa, Print): Richard L. Diamond, M.D. 3730 Falls Road, Baltimore, MD 21211

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 30 2001
32. Registrar's Signatura: Brenda G Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna Ruth Bull
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 11:00 P M

4a. Facility Name (If not institution, give street and number): Dulaney Towson Nursing Home
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-30-2552
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1912
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Anneslie
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 611 Overbrook Road
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edgar M. Bull
18. Mother's Name (First, Middle, Maiden Surname): Minnie Allison

19a. Informant's Name/Relationship (Type, Print): Joseph Huesman Attorney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 W. Pennsylvania Ave Suite 201 Towson, MD 21204

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park Cemetery
Date: 1/30/2001
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Congestive Heart Failure — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician
29c. License number: D53642
29d. Date signed (Month, Day, Year): Jan. 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 3007 E Northern Parkway Baltimore 21214

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Lenora B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EASTER BACHMAN
2. Date of Death (Month Day Year): JAN 27, 2001
3. Time of Death: 0845
4a. Facility Name (If not institution, give street and number): MARINER HEALTH @ NORTH ARUNDEL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 251.03.4766
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 23, 1913
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usuet Residenca of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 1021 MINNATONKA RD.
10f. Zip Code: 21144
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar In U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Buainess/Industry: OWNHOME

17. Father's Name (First, Middle, Last): WALLER L. DICKSON
18. Mother's Neme (First, Middle, Meiden Surname): PHRONIE PEEK

19a. Informant's Neme/Reletionship (Type, Print): LOUIS B. BACHMAN, JR GRANDSON
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 239 HIGHLANDER DR. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): METRO CREMATORY, INC.
Date: 29JAN01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: K. GREGORY FINK M01148
22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY, S. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth): a. Cerebrovascular Accident — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted.

29b. Signature and title of certifier:
29c. License number: D 38958
29d. Date signed (Month, Day, Year): 29 JAN 01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): DALJEET SIDHU, MD 1413 ANNAPOLIS RD. SUITE 106 ODENTON, MD 21113

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Easter Bachman
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0384-510
crn
William Barrett

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William H. Barrett, Sr
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 1923
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 164-14-8
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12.30.21
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 522 S. Lakewood Ave
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tank Guager
16b. Kind of Business/Industry: Oil

17. Father's Name (First, Middle, Last): Alvi Barrett
18. Mother's Name (First, Middle, Maiden Surname): Annabelle Baxley

19a. Informant's Name/Relationship (Type, Print): Jeanette Barrett
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 522 S. Lakewood Avenue Baltimore 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cem
Date: 1.27.01
20c. Location - City or Town, State: Baltimore Co., Md

21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: Kaczorowski Funeal Home, P.A. 1201 Dundalk Ave Baltimore, Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	left ventricular infarct	5 minutes
Due to (or es a consequence of): b.	perforation of coronary artery	5 minutes
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest Due to (or es e consequence of): c.	coronary artery disease, MVD	5 minute
d.		

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Netural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): January 23, 2001
28b. Time of Injury: 1600 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: during coronary catheterization
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Johns Hopkins Hospital
28f. Location (Street and Number or Rural Route Number, City or Town, State): 600 N. Wolfe Street Baltimore, Maryland

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter J. Gruber MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter J. Gruber M.D. 600 North Wolfe St. Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARLO BUCCI

2. Date of Death: Month JANUARY Day 25 Year 2001

3. Time of Death: 2:43 AM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 219-32-3554

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 23 1938

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md. 10b. County: Baltimore 10c. City, Town or Location: 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 1701 Holaview Rd. Apt 4c 10f. Zip Code: 21222 10g. Citizen of What Country: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurant

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Dominic Bucci

18. Mother's Name (First, Middle, Maiden Surname): Minnie Gasiorowski

19a. Informant's Name/Relationship (Type, Print): Carlo Bucci Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 634 S. Lehigh St. Baltimore, Md 21224

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery Date: 1-28-01

20c. Location - City or Town, State: Baltimore Co.

21. Signature of Funeral Service Licensee: Charles Raczorowski

22. Name and Address of Facility: Raczorowski Funeral Home, P.A. 1201 Dundalk Ave 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ISCEMIC BOWEL — 10 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: NON-SMALL CELL LUNG CANCER

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David M MD

29c. License number: 20313

29d. Date signed (Month, Day, Year): JANUARY 25 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RAPKO, M.D. JOHNS HOPKINS BAYVIEW 4940 EASTERN AVENUE BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 5 per fh G792 2/2/01 yf

AMENDED ITEM #18 per fhG791 013001 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02205

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR J. BENWAY

2. Date of Death — Month: JANUARY Day: 25 Year: 2001

3. Time of Death: 2:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 014-10-5905 ~~014-10-5956~~

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 30, 1918

9. Birthplace *(State or Foreign Country)*: MASSACHUSETTS

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HARFORD

10c. City, Town or Location: JARRETTSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3138 ANDOVER ROAD

10f. Zip Code: 21084

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 10 YRS. College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: STEELWORKER

16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Fathar's Name *(First, Middla, Last)*: UnKnown BENWAY

18. Mothar's Name *(First, Middle, Maiden Surnama)*: THERESA ~~MASON~~ Manson

19a. Informant's Name/Ralationship *(Type, Print)*: ADELE BENWAY

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3138 ANDOVER ROAD JARRETTSVILLE, MARYLAND 21084

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: HIGHVIEW MEM. GARDENS

Data: JAN. 29, 2001

20c. Location - City or Town, Stata: FALLSTON MARYLAND

21. Signature of Funaral Service Licensee ▶

22. Nama and Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not anter tha moda ot dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in daath)

a. VENTRICULAR TACHYCARDIA — 6 HOURS

Due to (or as a consequence ot):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Dua to (or as a consequence ot):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

END STAGE RENAL DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case retarred to medical examinar? 1☐ Yas 2☒ No

26. Place ot Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner ot Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner statad.

29b. Signature and title of certifier ▶ G Small MD

29c. License number: D43791

29d. Date signed *(Month, Day, Year)*: JANUARY 25 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): BOTTICELLO FRANKLIN SQUARE HOSPITAL, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signatura ▶ Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

BENWAY, ARTHUR

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02206

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET BARLOW
2. Date of Death — Month: JANUARY Day: 24 Year: 2001
3. Time of Death: 5:53AM
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS GERIATRIC CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-44-1003
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 19, 1945
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 406 S. BOND STREET
10f. Zip Code: 21231
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSES ASSISTANT
16b. Kind of Business/Industry: MEDICAL

17. Father's Name *(First, Middle, Last)*: ANDREW WILLIAM BARLOW
18. Mother's Name *(First, Middle, Maiden Surname)*: MARGARET CHRISTOPHER

19a. Informant's Name/Relationship *(Type, Print)*: LARRY BARLOW/ BROTHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 406 S. BOND STREET, BALTIMORE, MARYLAND 21231

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BAYVIEW CREMATORY — Date: 1/26/01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC VASCULAR DISEASE	15 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas Funicane MA
29c. License number: D24334
29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN GUTKIN CRNP JOHNS HOPKINS GERIATRIC CENTER

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Amy Blitstein

2. Date of Death: Month 01 Day 26 Year 2001

3. Time of Death: 11:23 am

4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-50-8795

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02/19/1959

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: HARFORD

10c. City, Town or Location: ABERDEEN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 920 OXFORD AVE.

10f. Zip Code: 21001

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MORTON SALAWITCH

18. Mother's Name (First, Middle, Maiden Surname): SYLVIA SILVERMAN

19a. Informant's Name/Relationship (Type, Print): DAVID BLITSTEIN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 920 OXFORD AVE. ABERDEEN, MD. 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): TIFERETH ISRAEL CONG

Date: 1/28/01

20c. Location - City or Town, State: ROSEDALE,MD.

21. Signature of Funeral Service Licensee: Robert Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. fungal sepsis (Candida Albicans) one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anorexia Nervosa

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0055722

29d. Date signed (Month, Day, Year): 01/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harford Memorial Hospital Seong Hyo Chin, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Renee G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
DENA	BORES	JANUARY 24, 2001	6:08 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-05-9201	1☐ M 2☒ F	78 Yrs.					OCT.29,1922	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2500 W. BELVEDERE AVENUE #601	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		COURT REPORTER	STATE OF MARYLAND

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
ZALMAN	BORISH	PEREL	PASTERNAK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DONALD LEVY / NEPHEW	10 STONEHENGE CIRCLE #5 - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SHAAREI ZION CONGREGATION	1/28/01	ROSEDALE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Scott M. Cuttler	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	1 HOUR
	Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SENILE DEMENTIA OF ALZHEIMER TYPE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert B. Shochet MD	D36356	JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT B. SHOCHET 2435 W. BELVEDERE AVENUE BALTIMORE, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 30 2001	▶ Jenna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David E. Bartlebaugh Sr.

2. Date of Death: Month January Day 25 Year 2001

3. Time of Death: 12:30 P.M.

4a. Facility Name (If not institution, give street and number): 7868 Leymar Road

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 182 22 1955

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Dec. 6, 1929

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7868 Leymar Road

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Jointer

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): David L. Bartlebaught

18. Mother's Name (First, Middle, Maiden Surname): Mary M. (not available)

19a. Informant's Name/Relationship (Type, Print): Donald Bartlebaugh / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7868 Leymar Road Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Stevensville Cemetery

Date: 1/27/01

20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: Donna M Zgamierowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Bladder Cancer — 8 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 031551

29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Russell A. DeLuca, M.D. 1600 S. Crain Highway Glen Burnie, Md. 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Bernard B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #30 PER D.V.R G791 1-30-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bobby DeBerry

2. Date of Death (Month, Day, Year): January 26, 2001

3. Time of Death: 0141

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-52-7102

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 22, 1949

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 513 Collins St.

10f. Zip Code: 21801

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sanitary Engineer

16b. Kind of Business/Industry: Sanitation

17. Father's Name (First, Middle, Last): Robert DeBerry

18. Mother's Name (First, Middle, Maiden Surname): Clander Johnson

19a. Informant's Name/Relationship (Type, Print): Mr. Ira Fitch (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Leadenhall St. Balto. Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 2/3/2001

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. DIABETES MI — JUT — 2/26/2001 — 15 MINS

Due to (or as a consequence of):
b. DIABETES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James W. Isaacs

29c. License number: D14256

29d. Date signed (Month, Day, Year): 1/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES W. ISAACS 517 DRUID HILL AVE. SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: James B. Fowler

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEBERRY, BOBBY SS#217-52-7102 514 1/26/01 0141

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Albert Cooper

2. Date of Death: Month Jan. Day 25 Year 2001

3. Time of Death: 12:20pm

4a. Facility Name (If not institution, give street and number): 2441 Spring Lake Drive

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-24-3585

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 4 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2441 Spring Lake Drive

10f. Zip Code: 21093

10g. Citizen of What Country? USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: '45-'47

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Cold Storage Warehousing

17. Father's Name (First, Middle, Last): Harry Cooper

18. Mother's Name (First, Middle, Maiden Surname): Susie Cole

19a. Informant's Name/Reletionship (Type, Print): Juanita Cooper/wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2441 Spring Lake Dr., Timonium, MD 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens | Date: 1/27/01

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name end Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in deeth): a. Metastatic Non-Small Cell Lung Cancer

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were eutopsy findings availeble prior to completion of ceuse of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: David S Ettinger MD

29c. License number: D17207

29d. Date signed (Month, Dey, Year): 01/26/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): David S. Ettinger, M.D. 401 N. Broadway, Wineburg Bldg., Balto., MD 21231

State Registrar

31. Dete filed (Month, Day, Year): JAN 30 2001

32. Registrer's Signeture: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02212

ANDREW CASTIGLIONE, JANUARY 24, 2001 @ 3:10AM
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew A. Castiglione
2. Date of Death (Month, Day, Year): January 24 2001
3. Time of Death: 3:10 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 113-20-5006
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1928
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 536 Anneslie Rd.
10f. Zip Code: 21212
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): court reporter
16b. Kind of Business/Industry: legal
17. Father's Name (First, Middle, Last): Andrea Castiglione
18. Mother's Name (First, Middle, Maiden Surname): Mary Bacchi
19a. Informant's Name/Relationship (Type, Print): Susan Castiglione/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 536 Anneslie Rd. Baltimore, MD 21212
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Calvary Cemetery
Date: 1/25/01
20c. Location - City or Town, State: Woodside, New York
21. Signature of Funeral Service Licensee: John D. Mitchell IV
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bladder cancer	18 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic lymphocytic leukemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature]
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

10

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, [signature]

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0405-510

CHERYLENE DORSEY

AMEND ITEM: #17, 18 PER F.H. G791 1-30-01 WR.
AMENDED ITEM #23a pt II, 27 per me G792 020101 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cherylene A. Dorsey

2. Date of Death: Month JANUARY, Dey 24, Year 2001

3. Time of Death: 6:35P.M.

4a. Facility Name (If not institution, give street and number): 1818 N.ELLAMONT STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 214-72-8666

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04 13 57

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1818 North Ellamont Street

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Drug Store

17. Father's Name (First, Middle, Last): Charles Dorsey ~~Jr.~~ SR.

18. Mother's Name (First, Middle, Maiden Surname): ~~Iola Smith~~ GLENDORIA SMITH

19a. Informant's Name/Relationship (Type, Print): Iola Jackson-Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3908 Carlisle Ave, Baltimore Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 2/1/01

20c. Location - City or Town, State: Baltimore Co, Md

21. Signature of Funeral Service Licensee: Glynn B. Yeke

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 25,2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Donna B Lewis

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02214

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marianna Nagle Davis

2. Data of Death: Month January Day 26, Year 2001

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 162-01-9592

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 20, 1910

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 719 Maiden Choice Lane Brookside 240

10f. Zip Code: 21228-6186

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): executive secretary

16b. Kind of Business/Industry: electrical supply

17. Father's Name (First, Middle, Last): Ralph W. Nagle

18. Mother's Name (First, Middle, Maiden Surname): Helen Toy

19a. Informant's Name/Relationship (Type, Print): Edmund C. Davis - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Maiden Choice Lane Brookside 240, Catonsville, MD 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Date: 1/30/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann Y. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. dementia and stage — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Myla M Carpenter

29c. License number: D 30989

29d. Date signed (Month, Day, Year): January 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myla M Carpenter MD 711 Maiden Choice Ln Catonsville MD

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: ▶ Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02215

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE E. DiPASQUALE
2. Date of Death: Month JANUARY Day 26, Year 2001
3. Time of Death: 1:30 AM
4a. Facility Name (If not institution, give street and number): STELLA MARIS AT MERCY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 214-20-3772
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 9 1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5707 BENTON HEIGHTS AVE.
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): HOMEMAKER
16b. Kind of Business/Industry: AT HOME

17. Father's Name (First, Middle, Last): HARRY WILLMAN
18. Mother's Name (First, Middle, Maiden Surname): LENA GARAFALO

19a. Informant's Name/Relationship (Type, Print): CAROL L. MARSHALL
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 08690: 411 HICKADEE WAY HAMILTON NEW JERSEY

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): HOLY REDEEMER
Date: JAN 29, 2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee:
22. Neme end Address of Facility: EVANS FUNERAL CHAPEL 21234, 8800 HARFORD ROAD PARKVILLE, MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. End Stage Congestive Heart Failure
Due to (or as a consequence of):
b. Cardiac Valvular Deseäse.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Deseäse

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier:
29c. License number: D40854
29d. Date signed (Month, Day, Year): JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 ST PAUL PL BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02216

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Deona Mildred Disney
2. Date of Death Month / Day / Year: Jan 28 2001
3. Time of Death: 8:50AM
4a. Facility Name *(If not institution, give street and number)*: 9832 Magledt Rd.
4b. City, Town, or Location of Death: Carney
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-32-4811
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 20 1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Carney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9832 Magledt Rd
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+): —
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: home

17. Father's Name *(First, Middle, Last)*: George Klebe
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Schulte

19a. Informant's Name/Relationship *(Type, Print)*: Irma Smith sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9832 Magledt Rd Baltimore Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. John's Lutheran Cem
Date: Jan 30 2001
20c. Location - City or Town, State: Parkville Md.

21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrythmia — 1 hour
Due to (or as a consequence of):
b. Atherosclerotic Heart Disease — 20 years
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D44604
29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael Sittel 8100 Harford Rd. Baltimore, Md 21234

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Donna L Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REGINA. H. DISNEY
2. Date of Death: Month JANUARY Day 24, Year 2001
3. Time of Death: 4:50 AM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-05-1102
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 23, 1910
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 600 LIGHT ST.
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White.

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home.

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): Rose Kellner

19a. Informant's Name/Relationship (Type, Print): Lee DROST (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 85 Willow Path Ct. BALTO. MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS Cem.
Date: 1/27/01
20c. Location - City or Town, State: Balto. MD.

21. Signature of Funeral Service Licensee: ▶ Paul M. Stella
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME CHTD. 7527 HARFORD RD. Balto. MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic carcinoma, unknown primary
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D43725
29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: ▶ D. Hoskins

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

JANUARY 24, 2001 4:50 a.m.

REGINA DISNEY

7

RKD

01-0445-510

JANNETTA

EL-AHAMED AMENDED ITEMS # 23,27,28a-f G792 020601 SS per M.E.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANNETTA D. EL-AHAMED

2. Date of Death: Month JANUARY Day 26, Year 2001

3. Time of Death: 5:15P.M.

4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-78-3140

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 03 1956

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1100 BOLTON ST. APT. 810

10f. Zip Code: 21201

10g. Citizen of What Country?: U S A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 2 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHILD CARE PROVIDER

16b. Kind of Business/Industry: PRIVATE DUTY

17. Father's Name (First, Middle, Last): JAMES A. RICHARDSON-EL, SR.

18. Mother's Name (First, Middle, Maiden Surname): HELEN JOHNSON

19a. Informant's Name/Relationship (Type, Print): SHEMALA BEY - SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 DELIGHT RD REISTERSTOWN MD 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 1-29-01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Glynis B. Hicks

22. Name and Address of Facility: MARCH FUNERAL HOME WEST 4300 WABASH AVE. BALTO. MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day, Year): 1-26-01

28b. Time of Injury: unknown M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject ingested drugs.

28e. Place of Injury - At home, farm, factory, office building, etc. (Specify): found at residence.

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1100 Bolton St., #810 Balt, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Titus

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Lorraine B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02219

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: Marie A. Fuhrer

2. Data of Death Month Day Yaar: January 25, 2001

3. Time of Death: 9:55 AM

4a. Facility Nama *(If not institution, giva street and number)*: Stella Maris

4b. City, Town, or Location of Death: Dulaney Valley

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-76-5645

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: July 4, 1912

9. Birthplace *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 14 Glade Avenue

10f. Zip Coda: 21236

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 8th; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa ratired)*: Homemaker

16b. Kind of Business/Industry: Domestic

17. Fathar's Nama *(First, Middla, Last)*: William Ruthkowski

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Mary Unknown

19a. Informant's Name/Ralationship *(Type, Print)*: George Fuhrer, III / Son

19b. Mailing Address *(Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 14 Glade Avenue Baltimore, Maryland 21236

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Loudon Park

Data: 1/29/01

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funaral Service Licansaa: David J. Weber

22. Nama and Addrass of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

Approximate Intarval Batwaen Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Dementia

Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☒ Yas 2☐ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurrad at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar: Moran Kowalewski MD

29c. Licansa number: D21022

29d. Data signad *(Month, Day, Yaar)*: 1-26-01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): M. KOWALEWSKI MD 7672 BELAIR RD BALTO MD. 21236

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 30 2001

32. Registrar's Signatura: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHEILA H. FLOOD
2. Data of Death Month Day Year: JAN 27 2001
3. Time of Death: 1:41 AM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 103-34-0027
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 7-25-1945
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD
10b. County: HOWARD CO
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5495 CEDAR LANE
10f. Zip Code: 21044
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE'S AID
16b. Kind of Business/Industry: NURSING

17. Father's Name (First, Middle, Last): FRED DAVIS
18. Mother's Name (First, Middle, Maiden Surname): WILLIBEA DAVIS

19a. Informant's Name/Relationship (Type, Print): FREDA DAVIS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 277 OLD ROUTE 202 B POMONA NY 10970

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEM
Date: 1-30-2001
20c. Location - City or Town, State: BALTO. CO. MD

21. Signature of Funeral Service Licensee: E.N. WALKER JR
22. Name and Address of Facility: ESTEP BROS. FUNERAL SERV. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. GENERALIZED PERITONITIS — 23 DAYS

Due to (or as a consequence of):
b. PERFORATION OF THE URINARY BLADDER — 24 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MULTI-ORGAN SYSTEM FAILURE

OCCLUSIVE ILIAC/FEMORAL/POPLITEAL ARTERIAL DISEASE, LEFT LEG

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: RENE L GELBER MD
29c. License number: D 17502
29d. Data signed (Month, Day, Year): JAN 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RENE L. GELBER MD, 10802 HICKORY RIDGE ROAD COLUMBIA MARYLAND 21044

State Registrar

31. Data filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille Fitzgerald

2. Data of Death Month: 1 Day: 25 Year: 01

3. Time of Death: 1090 PM

4a. Facility Name (If not institution, give street and number): GEC HW

4b. City, Town, or Location of Death: Balto

4c. County of Death: N. A

Funeral Director

5. Social Security Number: 219-18-3971

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): 1/23/17

9. Birthplece (State or Foreign Country): VA.

Usuel Residence of Decedent

10a. State: Md.

10b. County: N. A.

10c. City, Town or Location: Balto

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2630 E. Federal St.

10f. Zip Code: 21213

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Bleck, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)

Elamantary/Secondery (0-12): Morgan

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Machine Operator

16b. Kind of Business/Industry: Grown Cork Deal

17. Fathar's Nema (First, Middle, Last): Sam Fitzgerald

18. Mother's Neme (First, Middle, Meiden Sumame): Lucy Jane Williams

19a. Informent's Name/Reletionship (Type, Print): Doris McCoy

19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code): 4907 St Georges Ave Balto. Md. 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Steta 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Md. National Mem Pk

Deta: 1/30/01

20c. Location - City or Town, Stete: Laurel. Md

21. Signature of Funerel Service Licensee: Joseph G. Locks. Jr.

22. Name end Address of Facility: Joseph G. Locks. Jr. 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications thet causad tha daath. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onsat and Deeth

Immediate Cause (Finel disaase or condition resulting in daeth) e. Respiratory Failure — hours

Due to (or as e consequence of): Sepsis — Days

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated evants resulting in death) Last

b. Dua to (or es e consequence of): Peripheral Vascular Disease — years

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Chronic Obstructive Lung Disease

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes casa referred to medical exeminer? 1☐ Yas 2☒ No

28. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha bast of *my* knowledge, deeth occurred et tha *time*, data and piece, end dua to tha cause(s) and *menner* as stated. 2☐ **Medical Examiner:** On tha basis of examinetion end/or investigation, in *my* opinion, deeth occurred et the *time*, date end piece, end dua to tha ceuse(s) and *menner* steted.

29b. Signature and title of certifier

29c. License number: D17118

29d. Data signed (Month, Day, Yaar): Jan 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 117 E. Melrose Ave 21212

State Registrar

31. Data filed (Month, Dey, Year): JAN 30 2001

32. Registrar's Signeture: Donna D Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0387-510
jhm
MICHAEL
GOOLSBY

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02222

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Goolsby
2. Date of Death Month Day Year: JANUARY 24, 2001
3. Time of Death: 00:59 AM
4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-74-5817
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Dec. 13, 1955
9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4126 Wallard Street
10f. Zip Code: 21229
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Rigging
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Thomas C. Goolsby
18. Mother's Name *(First, Middle, Meiden Surneme)*: Ann Bach

19a. Informant's Name/Relationship *(Type, Print)*: Ann Goolsby - Mother
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4126 Wallard Street Baltimore, Maryland 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Bayview Crematory
Date: 1/27/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Timothy S. Har M01113
22. Name and Address of Feclity: David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Metastatic Cancer
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequenca of):
c.
Due to (or as a consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcoholism

23b. Did tobacco uas contributs to the causes of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JANUARY 24, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Susie Goss
2. Date of Death (Month, Day, Year): Jan. 25, 2001
3. Time of Death: 1:40am
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 244-03-1625
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-22-12
9. Birthplace (State or Foreign Country): GA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 115 Melrose Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 5th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping
16b. Kind of Business/Industry: Company

17. Father's Neme (First, Middle, Last): Allen Hunter
18. Mother's Name (First, Middle, Meiden Surneme): Mamie Hunter

19a. Informant's Name/Relationship (Type, Print): Edna Harris
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1022 Valley Street Baltimore, Maryland 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piace of Disposition (Neme of cemetery, cremetory or other piece): MD. Nat'l Mem. Pk. Cem. | Date: 01-31-01 | 20c. Location - City or Town, State: Laurel, MD

21. Signature of Funerai Service Licensee: [signature]
22. Name and Address of Feciiity: WM. C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in deeth) a.	Hypotension	3 days
Due to (or as a consequence of): b.	Pneumonia	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest — Due to (or es e consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Diabetis Mellitus

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner as steted. 2☐ **Medicat Examiner:** On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D17118
29d. Date signed (Month, Dey, Year): Jan 29, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Paul Schwartz MD 115 E. Melrose Ave 21212

State Registrar

31. Date filed (Month, Dey, Year): JAN 30 2001
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

RKD

01-0382-005

CHARLES GERMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27,28a,b,c,d,,ef per me G791 1/31/01 **Certificate of Death**

Reg. No. 2001 02224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES William GERMAN

2. Date of Death Month Day Year: JANUARY 23, 2001

3. Time of Death: 3:18P.M.

4a Facility Name (If not institution, give street and number): 800 CHESTER ROAD

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219 56 3841

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 13, 1951

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HARFORD

10c. City, Town or Location: JARRETTSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2046 Lox ROAD

10f. Zip Code: 21084

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 YRS.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMP.

16b. Kind of Business/Industry: AUTO MECHANIC + BODY WORK

17. Father's Name (First, Middle, Last): HARRY M. GERMAN, SR.

18. Mother's Name (First, Middle, Maidan Sumame): VALORIE A. GRAY

19a. Informant's Name/Relationship (Type, Print): TIMOTHY A. GERMAN, SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2110 LOX ROAD JARRETTSVILLE, MARYLAND 21084

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY

Date: JAN 31, 2001

20c. Location - City or Town, State: ROSEDALE MARYLAND

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: EVANS FUNERAL CHAPEL - BEL AIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ETHANOL INTOXICATION IN ASSOCIATION WITH HYPOTHERMIA

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete ceusa. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last

b.

Dua to (or es a consequanca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Menner of Death: 1☐ Naturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year) found: 1/23/01

28b. Time of Injury found: 3:05 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: subject drank alcohol and was exposed to the cold

28e. Placa of tnjury - At home, ferm, street, factory, offica building, etc. (Specify) found: under boat ramp

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 800 Chester Road Baltimore, Md

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, end dua to tha cause(s) and manner as steted. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and placa, end due to the cause(s) and mannar steted.

29b. Signature and title of certifier: M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 24, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): MARY G. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001

32. Registrer's Signature: for D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02225

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELSIE GREEN

2. Data of Death — Month: JANUARY Day: 23 Year: 2001

3. Time of Death: 1 Am

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-30-6243

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-3-1930

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1410 FRANKLIN ST.

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): -6- College (1-4or 5+): -0-

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Fathar's Name (First, Middle, Last): JAMES D. COOPER

18. Mother's Name (First, Middle, Meiden Surname): ELLA JONES

19a. Informant's Name/Relationship (Type, Print): JAMES E. COOPER(BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2007 WESTWOOD AVE. BALTIMORE, MARYLAND 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 1-30-2001

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signeture of Funeral Service Licensee: Jaatha D. Hubne

22. Name and Addrass of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediata Cause (Final disease or condition resulting in death): a. CANCER OF THROAT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: T Fowler md

29c. Licensa number: D30272

29d. Date signed (Month, Day, Year): 1/23/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS S. MILLER BON SECOURS HOSPITAL BALTIMORE, MD.

State Registrar

31. Data filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jess Rowland Higgs

2. Date of Death (Month, Day, Year): JANUARY 27 2001

3. Time of Death: 8:55 AM

4a. Facility Name (If not institution, give street end number): Franklin Square Hospital center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-12-0174

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 21, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1403 Winter Park Circle

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): shipyard worker

16b. Kind of Business/Industry: steel

17. Father's Name (First, Middle, Last): Jasper Higgs

18. Mother's Name (First, Middle, Maiden Surname): Mabel M. Gilbert

19a. Informant's Name/Relationship (Type, Print): Dolores M. Higgs - sister-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4913 Wilkens Avenue, Baltimore, Maryland 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery

Date: 1/31/01

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Ann G Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

HIGGINS

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA — 2 DAYS

Due to (or as a consequence of):

b. STROKE — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [/] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [/] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Sarraf MD

29c. License number: 203307

29d. Date signed (Month, Day, Year): 1/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAider SARRaf, 9006 Franklin SQUARE Drive, Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Frances G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02227

M00

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVERETT THOMAS HAY

2. Date of Death — Month: JAN. Day: 25 Year: 2001

3. Time of Death: 10:25AM

4e. Facility Name *(If not institution, give street and number)*: 205 East Joppa Rd. Apt. 505

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-10-1575

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Feb. 16, 1912

9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson- Baltimore County

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 205 East Joppa Rd. Apt. 505

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+): 4 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-Employed

16b. Kind of Business/Industry: Hay Brothers Ins. Co.

17. Father's Name *(First, Middle, Last)*: William Hay

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Wilson

19a. Informant's Name/Relationship *(Type, Print)*: William C. Hay (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4303 Starview Court Glen Arm, Md. 21057

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cem. — Date: 1-29-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Donald C. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR DISEASE — MONTHS

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Ebeling

29c. License number: D34827

29d. Date signed *(Month, Day, Year)*: 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES EBELING MD 7401 Osler Drive Towson, Md. 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Teresa G Sparks

FEB 1 2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02228

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM ELTON HALL
2. Date of Death Month / Dey / Yaer: JAN. 23 2001
3. Time of Death: 8:28 PM
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-03-3379
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 5-1-1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3802 Meghan Dr. Apt. 3H
10f. Zip Coda: 21236
10g. Citizan of What Country?: USA

11. Merital Stetus: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No — If Yas, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12): 12th grade — Collega (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa ratired)*: Insurance Salesman
16b. Kind of Businass/Industry: Insurance Industry

17. Fathar's Nama *(First, Middla, Last)*: Elton Ambrose Hall
18. Mothar's Nema *(First, Middle, Meiden Surname)*: Maude Virgie Sylvia

19a. Informant's Name/Ralationship *(Type, Print)*: Gladys E. Hall
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 3802 Meghan Dr. Apt. 3H Baltimore, Md. 21236

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cemafery, crematory or othar placa)*: Parkwood Cemetery — Data: 1-27-2001
20c. Location - City or Town, Stete: Baltimore, Md. 21234

21. Signature of Funeral Service Licensee: E.J. Lassahn
22. Name end Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused tha death. Do not enter tha moda ot dying, such as cardiec or raspiratory arrast, shock, or haart failura. List only ona cause on eech line.

Approximate Interval Between Onsat and Deeth

Immediata Causa (Finai diseasa or condition resulting in deeth): a. lung cancer — months
Due to (or as a consequenca of):
Sequantially list conditions, if any, leading to immadieta causa. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last:
b. Dua to (or as a consequanca of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undariying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings available prior to completion of cause of daath? 1 [ ] Yas 2 [ ] No

25. Was casa referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* hospice

27. Manner of Death: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigetion 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, deta and pleca, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or investigetion, in my opinion, deeth occurred at tha tima, data and placa, and due to the cause(s) and mennar stated.

29b. Signature and title of certifiar: Helen M Gordon MD
29c. Licensa number: D0051926
29d. Data signed *(Month, Day, Year)*: 1/24/01

30. Nama and address ot person who completed causa of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore, MD 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

HALL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#12 PER F.H. G791 1-31-2001 JAB

Certificate of Death

Reg. No. 2001 02229

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Ralph Hempfield

2. Date of Death (Month, Day, Year): Jan. 25, 2001

3. Time of Death: 7:30pm

4a Facility Name (If not institution, give street and number): 1849 N. Collington Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-05-1238

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-29-21

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1849 N. Collington Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th Grade

College (1-4or 5+): NA

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steelworker

16b. Kind of Business/Industry: Armco Steel Co.

17. Father's Name (First, Middle, Last): Michael Hempfield, Sr.

18. Mother's Name (First, Middle, Maiden Surname): LeVerse Montgomery

19a. Informant's Name/Relationship (Type, Print): Gladys Hempfield

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1849 N. Collington Avenue Baltimore, MD. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Druidridge Cemetery

Date: 02-01-01

20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Asbestosis, Coronary Artery Disease, Gastro Esophageal Reflux Disease

23b. Did tobacco uas contributa to the cause of death? 1☐ Yaa 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D 36082

29d. Date signed (Month, Day, Year): 1/26/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): S. RAMESH 2323 Orleans St, Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN G. HARTHAUSEN
2. Date of Death (Month, Day, Year): JANUARY 28, 2001
3. Time of Death: 0700
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 218-36-8461
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 10, 1941
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 105 KENT ROAD
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1959-1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: BINDERY

17. Father's Name (First, Middle, Last): ALBERT HARTHAUSEN
18. Mother's Name (First, Middle, Maiden Surname): IRMA BUSHONG

19a. Informant's Name/Relationship (Type, Print): MADALYNNE M. HARTHAUSEN (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 KENT ROAD, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: FEB. 1, 2001
20c. Location - City or Town, State: BROOKLYN PARK, MD.

21. Signature of Funeral Service Licensee: Paul Logan
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CORONARY ARTERY DISEASE	>10 years
Due to (or as a consequence of): b.	HYPERTENSION	>2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J Corcoran MD
29c. License number: D46328
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2500 KERNAN DRIVE · BALTO, MD 21207

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Jenna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANTHONY HAWKINS
2. Date of Death: Month 01 Day 23 Year 2001
3. Time of Death: 8:35PM
4a. Facility Name (If not institution, give street and number): Joseph Ritchie Hospice
4b. City, Town, or Location of Death: Balto
4c. County of Death: N. A.

Funeral Director

5. Social Security Number: 214 85 1160
6. Sex: 1 [X] M 2 [ ] F
7. Age (In/yrs. last birthday): 31 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/9/69
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md. | 10b. County: N. A. | 10c. City, Town or Location: Balto | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1433 Holbrook AVE | 10f. Zip Code: 21202 | 10g. Citizen of What Country? U.S.A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Furniture Mover

16b. Kind of Business/Industry: ALLEN Moving & Storage

17. Father's Name (First, Middle, Last): BENJAMIN HAWKINS

18. Mother's Name (First, Middle, Maiden Surname): JANICE FRANKLIN

19a. Informant's Name/Relationship (Type, Print): JANICE MILLER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1433 Holbrook St' Balto, Md. 21202

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk | Date: 1/31/01

20c. Location - City or Town, State: ARBUTUS. Md

21. Signature of Funeral Service Licensee: Joseph G. Locke Jr

22. Name and Address of Facility: Joseph G. Locke Jr 3/H. 1304 N. Central Ave

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8:35 PM

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. GASTRIC ADENOCARCINOMA — 6 MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or es a consequence of):

c. Due fo (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACQUIRED IMMUNODEFICIENCY SYNDROME

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Douglas Ross MD | 29c. License number: D0026327 | 29d. Date signed (Month, Day, Year): 01-24-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOUGLAS D. ROSS, 6114 CAMPFIRE, COLUMBIA, MD 21045

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Geneva G Sparks

To be Completed by Physician and Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Anthony Hawkins 1-23-01

DHMH 16 Rev 6/95

ORIGINAL

01-0459-510

JOHN HOUCK

ASP AMENDED ITEMS# 23,27,&28a-f per ME G793 030601 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN. D HOUCK

2. Date of Death: Month JANUARY Day 27 Year 2001

3. Time of Death: 1555

4a. Facility Name (If not institution, give street and number): 4422 RASPE AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A.

Funeral Director

5. Social Security Number: 218-46-9548

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 1, 2001

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 4422 RASPE AVE

10f. Zip Code: 21206

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CORRIER

16b. Kind of Business/Industry: DELIVERY CO.

17. Father's Name (First, Middle, Last): JOHN T. HOUCK

18. Mother's Name (First, Middle, Maiden Surname): MARY ANN MARTIS

19a. Informant's Name/Relationship (Type, Print): JOHN T. HOUCK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3002 WESTWOOD CT. BALTO. MD 21234

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY.

Date: 1/30/01

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Hartley Miller

22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME CH'TD. 7527 HARFORD RD. BALTO. MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CIRRHOSIS COMPLICATED BY ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? ☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? ☒Yes 2☐No

25. Was case referred to medical examiner? ☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day, Year) found: 1-27-01

28b. Time of Injury found: 3:30 PM

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4422 Raspe Ave., Baltimore, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M. Titus

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa Janicki
2. Date of Death Month: January Day: 29 Year: 2001
3. Time of Death: 16:51
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 219-10-5252
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 10, 1926
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 843 Mildred Ave
10f. Zip Code: 21222
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yrs; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: OwnHome

17. Father's Name (First, Middle, Last): Walter Czarski
18. Mother's Name (First, Middle, Maiden Surname): Marcianna Kmieciak

19a. Informant's Name/Relationship (Type, Print): Benjamin Janicki
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 843 Mildred Ave, Dundalk, Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus
Date: Feb. 01 2001
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: John E. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not antar tha moda of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hypotension	2 days
Due to (or as a consequance of): b.	Presumed Sepsis	1 month
Sequantially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated events rasulting in daath) Last Due to (or es e consequence of): c.	Bacterial endocarditis	4 months
Due to (or es e consequence of): d.	Rhumatic heart disese	Many years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

Diabetes type II, atrial fibiation, Stroke Secondary to bacterial endocarditis, history of myocardial Infaction, history of pulmonary embus, End Staye renal disese

23b. Did tobacco usa contribute to the cause of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa raferred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit case.

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha time, date and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Ian Brown MD
29c. License number: Res-00
29d. Date signed (Month, Day, Year): January 29 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Ian Brown 600 N. Wolfe St. Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02234

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gloria H James

2. Date of Death (Month Day Year): JANUARY 17, 2001

3. Time of Death: 8:27 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 174-26-8603

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09 09 32

9. Birthplace *(State or Foreign Country)*: P.A.

Usual Residance of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Streat and Number: 6000 Belona Ave

10f. Zip Coda: 21212

10g. Citizen of What Country?: U.S.A.

11. Merifel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 12th grade; Collega (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Operation Room

16b. Kind of Business/Industry: Ostien Hospital

17. Fathar's Name *(First, Middle, Last)*: Nelson King

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Carman Barge

19a. Informent's Name/Ralationship *(Type, Print)*: Deborah Johnson-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 5700 Ogontz Ave, Phila P.A. 19141

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cematary, cramatory or othar piece)*: King Memorial Park

Data: 1/26/01

20c. Location - City or Town, Stata: Randallstown, Md

21. Signature of Funaral Service Licensee: John B. Johnson Jr.

22. Nama and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or respiretory arrest, shock, or haart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in deeth)

a. CIRRHOSIS

Dua to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Ceuse (Diseese or injury that initiated evants rasulting in daath) Last

Dua to (or es a consequence ot):

c. LEFT VENTRICULAR HYPERTROPHY

Due fo (or as a consequence of):

d.

Part II. **Other signifficant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☑ Yas 2☐ No

24b. Wara autopsy findings available prior to completion ot cause of death? 1☑ Yas 2☐ No

25. Wes case raferred to medicat exeminer? 1☐ Yas 2☑ No

26. Placa of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, straet, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and menner stated.

29b. Signatura and title of certifier: Taqi MD Pathologist

29c. Licansa number: D 28244

29d. Data signed *(Month, Day, Year)*: 1-18-01

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): FOWZIA TAQI, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrer's Signeture: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02235

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Leroy Jones, Sr.
2. Date of Death Month Day Year: January 24, 2001
3. Time of Death: 8:30 AM
4a. Facility Name *(If not institution, give street and number)*: Home, 4221 Hickory Avenue Apt. C
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-42-4973
6. Sex: ☒ 1 M 2 ☐ F
7. Age *(In yrs. last birthday)*: 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 29, 1945
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2 ☐ No
10e. Street and Number: 4221 Hickory Avenue Apt. C
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married ☒ 2 Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☒ 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Conductor
16b. Kind of Business/Industry: Conrail

17. Father's Name *(First, Middle, Last)*: Vernon C. Jones
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence

19a. Informant's Name/Relationship *(Type, Print)*: Sandra Jones Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4221 Hickory Avenue Apt. C Baltimore, MD 21211

20a. Method of Disposition: 1 ☐ Burial ☒ 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balto-Washinton Crem.
Date: 1/29/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Terry H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinomatosis
Due to (or as a consequence of):
b. Bronchogenic Lung Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Cancer of the Larynx
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Chronic Alcoholism

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D. Simon-Beltrans.
29c. License number: D10732
29d. Data signed *(Month, Day, Year)*: 1-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Diadema Simon-Beltran 701 W. 36th Street Baltimore, MD 21211

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET JAREMKO
2. Date of Death: Month JANUARY Day 28 Year 2001
3. Time of Death: 22:07
4a. Facility Name (If not institution, give street and number): GOOD-SAMARITAN-HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 216-16-2816
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 17, 1923
9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3016 Oak Forest DR.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): circuit board assembler
16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Charles Kirk
18. Mother's Name (First, Middle, Maiden Surname): Eleanor unknown

19a. Informent's Name/Relationship (Type, Print): Mike Jaremko
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 999 Rohe Farm Lane Chase Md 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: Feb 1 2001
20c. Location - City or Town, State: Parkville, Md.

21. Signature of Funeral Service Licensee: ▶ Keisha B Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial infarction

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contributa to the cauaa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Kofi A. Appiah, Resident Physician
29c. License number: P18450
29d. Date signed (Month, Day, Year): JANUARY 28 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): GOOD-SAMARITAN-HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE/MD 21239-2995

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: ▶ Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WOLFE JOFFE

2. Date of Death (Month, Day, Year): JANUARY 26, 2001

3. Time of Death: 3:00 AM

4a. Facility Name (If not institution, give street and number): JEWISH CONVALESCENT CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-34-1999

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 4, 1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7025 CONCORD ROAD

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII NAVY

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): ABRAHAM JOFFE

18. Mother's Name (First, Middle, Maiden Surname): RACHAEL BLUMBERG

19a. Informant's Name/Relationship (Type, Print): BENJAMIN JOFFE / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7025 CONCORD ROAD - BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP CEMETERY

Date: 1/28/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia

Due to (or as a consequence of):
b. Oropharyngeal dysphagia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Dementia.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 30339

29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Milan Wister, MD 4000 Old Court Rd, Baltimore, MD 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Geneva D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02238

Jensen, Catherine

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine M. Jensen

2. Date of Death (Month, Day, Year): Jan. 27 2001

3. Time of Death: 1015 am

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-12-9789

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 24, 1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8456 Miramar Road

10f. Zip Code: 21122

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Conrad Mack

18. Mother's Name (First, Middle, Maiden Surname): Cunigunda Foehrkolb

19a. Interment's Name/Relationship (Type, Print): Gloria Mason (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 Granada Road Pasadena, MD 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Glen Haven Mem. Park

Date: 1/30/01

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Sharron M Liggett

22. Name and Address of Facility: Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, MD 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction / Arrest	2 hrs
Due to (or as a consequence of): b.	Cardiamyopathy	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Coronary Artery Disease	10 yrs
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Valvulopathy Mitral Valve Regurgitation Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary W. Jones MD

29c. License number: D30111

29d. Date signed (Month, Day, Year): Jan. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary W. Jones MD 4714 Colonel Ewell Ct Upper Marlboro Md 20772

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Kelly

2. Date of Death (Month, Day, Year): JANUARY 28, 2001

3. Time of Death: 6:45 AM

4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-01-8048

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 5, 1907

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3320 Benson Avenue

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Law Firm

17. Father's Name (First, Middle, Last): John Patrick Kelly

18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Miller

19a. Informant's Name/Relationship (Type, Print): Dolores Sattler / friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 824 Corbett Road, Monkton, Maryland 21111

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 2/1/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RIGHT LOWER LOBE PNEUMONITIS — 48 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST COLOSTOMY FOR CARCINOMA OF RECTUM. CORONARY HEART DISEASE HYPERTENSION. OSTEOPOROSIS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN

29c. License number: D16200

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 720-C MAIDEN CHOICE LA., CATONSVILLE 21228 DR. N. M. MACHIRAN

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE I. KOLB

2. Date of Death: Month JANUARY Day 27 Year 2001

3. Time of Death: 5:08 A.M.

4a. Facility Name (If not Institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-07-0138

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 22, 1920

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 606 S. EAST AVE.

10f. Zip Code: 21224

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HARVEY JETT

18. Mother's Name (First, Middle, Maiden Surname): PEARL HAYNIE

19a. Informant's Name/Relationship (Type, Print): MARK KOLB

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5679 ARNHEM RD. BALTO. MD. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): MEADOWRIDGE MEM. Date: JAN. 31 2001

20c. Location - City or Town, State: HOWARD CO. MD.

21. Signature of Funeral Service licensee: Thomas J. Skalda Jr.

22. Name and Address of Facility: HOFFMAN-SKALDA 3218 HUDSON ST. BALTO. MD. 21224

KOLB, FLORENCE

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — ONE WEEK

Due to (or as a consequence of):
b. BILATERAL PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIVERTICULITIS, RECTOVAGINAL FISTULA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D-38754

29d. Date signed (Month, Day, Year): 01-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MALIKA WASEEM, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John King

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 0825

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-26-3208

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 28 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No — X

10e. Street and Number: 317 Galway Road

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — X. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — X. Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Handyman

16b. Kind of Business/Industry: Hospitality

17. Father's Name (First, Middle, Last): John Joseph King, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Rose Agnes Mooney

19a. Informant's Name/Reletionship (Type, Print): Rose A. Lister/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 E. Joppa Rd., Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State — X; 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Balto. Wash. Crematory

Date: 1/31/01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 70 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Arteriosclerotic Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rectal Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown — X

24a. Was an autopsy performed? 1☐ Yes 2☒ No — X

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No — X

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No — X

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient — X 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural — X 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. — X 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Bergeson MD.

29c. License number: D0055849

29d. Date signed (Month, Day, Year): January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Bergeson St. Agnes Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02242

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Julia Kempf

2. Date of Death Month Day Year: JAN. 25 2001

3. Time of Death: 5:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-12-3607

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 18, 1904

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 31 Silver Fox Court

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+): n/a

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietitian

16b. Kind of Business/Industry: Hospital/Health Care

17. Father's Name *(First, Middle, Last)*: James J. Horan

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Fritag

19a. Informent's Name/Relationship *(Type, Print)*: Dolores K. Shamer/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 31 Silver Fox Court, Cockeysville, MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Park

Date: 1/27/01

20c. Location - City or Town, State: Hillendale, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, Maryland 21093

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 17550

29d. Date signed *(Month, Day, Year)*: 1-25-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Eddie Nakuda, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KEMPF, DOROTHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Lambert
2. Date of Death: Month Jan. Day 24 Year 2001
3. Time of Death: 11:19 a.m.
4a. Facility Name (If not institution, give street and number): 2906 Hilldale Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 243-30-5147
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1934
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2906 Hilldale Ave.
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown | College (1-4or 5+)
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Grinder
16b. Kind of Business/Industry: Armco Steel

17. Father's Name (First, Middle, Last): Charles Lambert
18. Mother's Name (First, Middle, Maiden Surname): Adeline

19a. Informant's Name/Relationship (Type, Print): Alma Lambert-wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2906 Hilldale Ave. Baltimore, Maryland 21215

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem. | Date: 1/31
20c. Location - City or Town, State: Owings Mills Maryland

21. Signature of Funeral Service Licensee: ▶ Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial Infarction
Due to (or as a consequence of):
b. Hypertension
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequance of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
Gout
Obesity

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Homa 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Craig Gold DO
29c. License number: H 53088
29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Craig Gold DO 222 West Coldspring Lane Baltimore, Maryland 21210

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001
32. Registrar's Signature: ▶ Sandra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lena S. Love

2. Date of Death: Month January Day 25 Year 2001

3. Time of Death: 2300

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 224-30-9165

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-10-10

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 433 Notre Dame Lane

10f. Zip Code: 21212

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: in & out of home

17. Father's Name (First, Middle, Last): Samuel Saddler

18. Mother's Name (First, Middle, Maiden Surname): Anita Boomer

19a. Informant's Neme/Relationship (Type, Print): Samuel Lucas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 860 Benninghaus Road Baltimore, Maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery | Date: 02-01-2001

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: ▶ Darnell L. Hunter

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon cancer — six months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark Levis MD

29c. License number: D0052391

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Levis Department of Medicine, Union Memorial Hospital, 201 University Parkway, Baltimore

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: ▶ Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARA RUTH LEWIS

2. Date of Death (Month, Day, Year): January 26, 2001

3. Time of Death: 8:20PM

4a. Facility Name (If not institution, give street and number): St Joseph Hospital

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-34-6148

6. Sex: 1☐ M 2☐ F XX

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 1, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☐ Yes 2☐ No

10e. Street and Number: 2 East Lake Avenue

10f. Zip Code: 21212

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Galbreath Selfe

18. Mother's Name (First, Middle, Maiden Surname): Ruth Kenly

19a. Informant's Name/Relationship (Type, Print): James Lewis Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 257 Oyster Shell Cove Bethany Beach Delaware 19930

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gar. | Date: 1/30/01

20c. Location - City or Town, State: Lutherville, Maryland

21. Signature of Funeral Service Licensee: Dennis Sheehan Kenaka

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia (Hypostatic)

Due to (or as a consequence of):
b. Fractured Left Hip

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Arteriosclerotic Cardio Renal Vascular Disease

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 1-10-01

28b. Time of Injury: 8:00A M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Fall To Floor

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Own Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2 E Lake Ave

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F O'Donnell MD

29c. License number: D-09383

29d. Data signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F O'Donnell MD 11 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Data filed (Month, Day, Year): JAN 3 0 2001

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02246

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ABRAHAM I. LEVIN

2. Date of Death Month / Day / Year: JAN 26 2001

3. Time of Death: 1:40 PM

4a. Facility Name *(If not institution, give street and number)*: LEVINDALE HEBREW HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-01-7844

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 4 1904

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 5922 CROSS COUNTRY BLVD

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OWNER

16b. Kind of Business/Industry: GROCERY

17. Father's Name *(First, Middle, Last)*: JACOB LEVIN

18. Mother's Name *(First, Middle, Maiden Surname)*: REBECCA DEINER

19a. Informant's Name/Reletionship *(Type, Print)*: DR. STANLEY LEVIN/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5922 CROSS COUNTRY BLVD BALTIMORE, MD. 21215

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: (ANSHE EMUNAH)-AITZ CHAIM

Date: 1/28/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Robert Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Head injuries with complications — 6 weeks

Due to (or as a consequence of):
b. COPD — year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c. Alzheimer's Disease

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Glaucoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Naturel 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 12/13/00

28b. Time of Injury: 7:30 P M

28c. Injury at Work? 1 ☐ Yes 2 X No

28d. Describe how injury occurred: SUBJECT Fell

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Levindale NURSING HOME

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 2434 W. Belvedere AVE. Baltimore, MD

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan M. Levy MD

29c. License number: D33943

29d. Date signed *(Month, Day, Year)*: 1/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan Levy Levindale 2434 W Belvedere Balto. 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACK L. LEVIN

2. Date of Death: Month January Day 25 Year 2001

3. Time of Death: 2:00 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Balto. City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-16-3238

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 2, 1912

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☐ Yes 2 X No

10a. Street and Number: 725 MT. WILSON LANE #435

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4+ College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRESIDENT

16b. Kind of Business/Industry: ADVERTISING AGENCY

17. Father's Name (First, Middle, Last): JOSEPH HERBERT LEVIN

18. Mother's Name (First, Middle, Maiden Surname): THERESA STERN

19a. Informant's Name/Relationship (Type, Print): DAVID JONATHAN LEVIN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12601 TIMBERGROVE ROAD - REISTERSTOWN, MD 21136

20a. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY Date: 1/28/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Scott M. Cutler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastro-intestinal Bleed

Due to (or as a consequence of):

b. dehydration

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amy M. Dvorcek, DO

29c. License number: RE5000

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amy M. Dvorcek, DO 2401 West Belvedere Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Patient known as Levin, Jack

h

DO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 23B, 20B PER PHY,F.H. G792 2-6-01 WR. *Certificate of Death* Reg. No. 2001 02248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Thomas Murphy
2. Data of Death Month Day Year: January 25 2001
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-60-0168
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 26, 1952
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 100 Tree Top Court
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 01
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Flight Engineer
16b. Kind of Business/Industry: Military

17. Father's Name (First, Middle, Last): Thomas V. Murphy
18. Mother's Name (First, Middle, Maiden Surname): Edith G. Horn

19a. Informant's Name/Relationship (Type, Print): Cathy Murphy/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Tree Top Court, Timonium, MD 21093

20a. Method of Disposition: 1 [X] Burial 2 [X] ~~Cremation~~ 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of Cemetery, Crematory, Other Place): DRUID RIDGE CEMETERY ~~Druid Ridge Cemetery~~
Date: 1/29/01
20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: Lowell M. Lemmon
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral Infarction — two months

Due to (or as a consequence of):
b. Trousseaus Syndrome — three month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Metastatic Pulmonary Adenocarcinoma — One year

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably ~~4 [ ] Unknown~~

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marshall A. Levine, M.D.
29c. License number: D17873
29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marshall A. Levine 6569 No. Charles St. Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature:

ORIGINAL

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Murphy, David

45

1+1

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02249

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Helen Mary Mulligan
2. Date of Death Month Dey Year: January 26, 2001
3. Time of Death: 4:30 am
4a Facility Neme (If not institution, give street end number): 1746 East Lombard Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 217-22-1811
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthdey): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/29/1926
9. Birthplace (State or Foreign Country): Poland

Usuat Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1746 East Lombard Street
10f. Zip Code: 21231
10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Clerk
16b. Kind of Business/Industry: Court System

17. Fether's Name (First, Middle, Last): Bernard Widomski
18. Mother's Neme (First, Middle, Meiden Surneme): Mary Presnell

19a. Informant's Neme/Relationship (Type, Print): Patricia Mulligan / daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 1001 Hanson Road Joppa, Maryland 21085

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other plece): Holy Rosary Cemetery
Date: 1/30/01
20c. Location - City or Town, State: Baltimore Maryland

21. Signeture of Funeret Service Licensee: David J Weber
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Renal Failure — few years

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Part I.: severe peripheral vascular disease.

23b. Did tobacco uss contributa to ths causs of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Couid not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and placa, end due to the ceuse(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and pleca, snd due to the cause(s) and manner stated.

29b. Signeture and title of certifier: MD
29c. License number: D0052243
29d. Date signed (Month, Dey, Year): 01/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jacob Bryan Blumentha/5505 Hopkins Bayview Circle, Baltimore. MD 21224

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 30 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02250

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE McCONNELL
2. Data of Death — Month: JAN Day: 27 Year: 2001
3. Time of Death: 23:00 pm
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: MARYLAND

Funeral Director

5. Social Security Number: 212-18-4103
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Data of Birth (Month, Day, Year): 11-04-1910
9. Birthplace (State or Foreign Country): BALTIMORE, MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: ESSEX
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 640 ROCKAWAY BEACH AVE
10f. Zip Code: 21220
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: IN OWN HOME

17. Father's Name (First, Middle, Last): HENRY PRELL
18. Mother's Name (First, Middle, Maiden Surname): LOUISE ZOCH

19a. Informant's Name/Relationship (Type, Print): COUSIN ROSE COMI
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 640 ROCKAWAY BEACH AVE, BALTO MD. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE NATIONAL
Date: 1/31/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Maria D. Zennier
22. Name and Address of Facility: JOSEPH N. ZANNINO JR. F.H. 263 S. CONKLING ST. BALTIMORE, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CELLULITIS
HYPERNATREMIA
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Abkhan, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JAN, 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABID KHAN, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, DEPARTMENT OF MEDICINE BALTIMORE MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02251

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Ogier Maddox

2. Date of Death (Month, Day, Year): JANUARY 26, 2001

3. Time of Death: 4:50 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-07-5823

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Sparks

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15200 Wheeler Lane

10f. Zip Code: 21152

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Herbert Leakin Ogier

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Raymond Ballard

19a. Informant's Name/Relationship *(Type, Print)*: Henry Stansbury/Personal Rep.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6200 Foxhall Farm Rd., Catonsville, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Dulaney Valley Memorial Gardens

Date: 1/30/01

20c. Location - City or Town, State: Timonium, MD 21093

21. Signature of Funeral Service Licensee: Bryan W. Clary

Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR INFARCTION — 6 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Beatriz P. Dizon M.D

29c. License number: D 0014692

29d. Date signed *(Month, Day, Year)*: January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BEATRIZ P. DIZON, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Geneva B Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Maddox, Margaret.

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET A. MAJKA
2. Data of Death: Month JANUARY Day 28, Year 2001
3. Time of Death: 1:00 PM
4a. Facility Name (If not institution, give street and number): FAIRFIELD NURSING HOME
4b. City, Town, or Location of Death: CROWNSVILLE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215-28-5896
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Yaer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JULY 13, 1931
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. Steta: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: MILLERSVILLE
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 601 STONE WHEEL COURT EAST
10f. Zip Code: 21108
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☐ No Specify:
14. Rece - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): CUSTODIAN
16b. Kind of Business/Industry: ELEMENTARY SCHOOL

17. Father's Name (First, Middle, Last): PERCY E. CROSBY
18. Mother's Name (First, Middle, Maidan Surnama): HATTIE RYAN

19a. Informent's Name/Ralationship (Type, Print): THERESA BAPISTELLER (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 601 STONE WHEEL COURT, MILLERSVILLE, MD. 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetary, cramatory or other place): CEDAR HILL CEMETERY
Date: JAN. 31, 2001
20c. Location - City or Town, State: BROOKLYN PARK, MD.

21. Signature of Funeral Service Licensaa: Paul D. Hagan
22. Nama and Addrass of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List onlyone causa on aach lina.

Approximate Interval Batween Onset and Death

Immediata Causa (Final disaase or condition resulting in death)
a. Aspiration Pneumonia — Dua to (or as a consequence of): — 1 day

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initieted evants rasulting in death) Last
b. — Dua to (or as a consequence of):
c. — Due to (or as e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case rafarred to medical examinar? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of cartifier: D. Shu
29c. Licensa number: D 38458
29d. Data signad (Month, Day, Year): 1/30/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. DALJEET SIDHU, M.D., 1413 ANNAPOLIS, ROAD, ODENTON, MD. 21113

State Registrar

31. Data filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Jeanine B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02253

MASKELL, DANIEL

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL V MASKELL
2. Date of Death: Month JANUARY Day 25 Year 2001
3. Time of Death: 07.00 AM
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-12-4587
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 24 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9615 Haven Farm Rd #D
10f. Zip Code: 21128
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: automobiles

17. Father's Name (First, Middle, Last): Daniel Maskell
18. Mother's Name (First, Middle, Maiden Surname): Marie Gray

19a. Informant's Name/Relationship (Type, Print): Helen J. Maskell wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128: 9615 Haven Farm Rd #D Baltimore Md

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Ch. Cem. | Date: Jan 29 2001
20c. Location - City or Town, State: Hydes, Maryland

21. Signature of Funeral Service Licensee: Kenda L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY EDEMA — 2 WEEKS

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MERKEL CELL SALIVARY CANCER
ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Cyril Ruwende MEDICAL OFFICER OF THE DAY
29c. License number: D0056001
29d. Date signed (Month, Day, Year): 01/25/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CYRIL RUWENDE, MD; 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LORRAINE EMMA MACHI

2. Date of Death (Month, Day, Year): JAN. 26, 2001

3. Time of Death: 8:04 am

4a. Facility Name (If not institution, give street and number): 1511 BANK STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-28-4866

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 15, 1932

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1511 BANK STREET

10f. Zip Code: 21231

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): FREDERICK DAWSON

18. Mother's Name (First, Middle, Maiden Surname): MARY DAWSON

19a. Informant's Name/Relationship (Type, Print): FREDERICK McGEE/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1511 BANK STREET, BALTIMORE, MARYLAND 21231

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): BAYVIEW CREMATORY | Date: 1/30/01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina. (Approximata Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Ischemic heart disease

Due to (or as a consequence of):
c. Hypertension

Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.: Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]

29c. License number: D0021667

29d. Date signed (Month, Day, Year): 01/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GUY A. CARRENARD, M.D. 242 S. BROADWAY, BALTIMORE, MARYLAND 21231

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#18 perFHG791 1/30/2001 EW

Certificate of Death

Reg. No. 2001 02255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID MORRIS

2. Date of Death Month Day Year: JANUARY 27, 2001

3. Time of Death: 12:35 AM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-01-6651

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): OCT 12 1903

9. Birthplace (State or Foreign Country): MD

Usual Residance of Decedant

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yas 2 [X] No XX

10e. Street and Number: 130 SLADE AVE. APT. 420

10f. Zip Code: 21208

10g. Citizan of What Country? USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed X 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No X If Yas, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No X Specify:

14. Race - Amaricen Indian, Black, White, etc. Specify: WHITE

15. Decedant's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): CHAUFFEUR

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): ABRAHAM MORRIS

18. Mother's Nama (First, Middle, Maidan Surname): ESTHER ~~FEINGOLD~~ Finegold

19a. Informant's Name/Raiationship (Type, Print): MRS.EMILY UDELL HYMAN/SISTER

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 130 SLADE AVE APT. 420 BALTIMORE,MD. 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cemetary, cramatory or other place): BALTIMORE HEBREW

Data: 1/28/01

20c. Location - City or Town, Stata: REISTERSTOWN,MD.

21. Signature of Funaral Service Licensee: Jay Allan Levi

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Daath

Immediata Causa (Final disaasa or condition rasulting in death): a. SEPSIS

Dua to (or as a consaquance of):

Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last:

b. Dua to (or as a consequence of):

c. Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical axaminar? 1 [ ] Yas 2 [X] No

26. Piece of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daath occurred at the tima, data and ptace, and dua to tha causa(s) and manner stated.

29b. Signature and title of cartifier: MD

29c. License number: D44505

29d. Data signed (Month, Day, Year): January 27, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): AJ IMPERIAL, JR. MD — NWHC.

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signatura: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN NEWKIRK
2. Date of Death (Month, Day, Year): JANUARY 24, 2001
3. Time of Death: 16 10 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-18-7379
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/16/1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edmondson Heights
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 1514 Kirkwood Rd.
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Joseph E. Bullock
18. Mother's Name (First, Middle, Maiden Surname): Helena Anne Donovan

19a. Informant's Name/Relationship (Type, Print): John Newkirk/ husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1514 Kirkwood Rd. Baltimore, Maryland 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 1/29/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Thomas J. Stanton
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. INTRA CRANIAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Ravi MD
29c. License number: D37333
29d. Date signed (Month, Day, Year): JANUARY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 8 per informant G792 2/9/01 yf

Certificate of Death

Reg. No. 2001 02257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin G. Nevins

2. Date of Death: Month: January Day: 28 Year: 2001

3. Time of Death: 11:50 AM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-12-9480

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~May 29~~ 5/20, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland 10b. County: N/A 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1111 Fallshill Drive 10f. Zip Code: 21211 10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [XX] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [XX] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Operator

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Joseph Nevins

18. Mother's Name (First, Middle, Maiden Surname): Daisy Beckford

19a. Informant's Name/Relationship (Type, Print): Margaret Nevins Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 Fallshill Drive, Baltimore, MD 21211

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory

Date: 1/30/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: AT 2438946

29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 E. University Parkway Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joyce W. Owens
2. Date of Death: Month January Day 28 Year 2001
3. Time of Death: 1:00 pm
4a. Facility Name (If not institution, give street and number): 1918 N. Bentalou Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 247-60-9894
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 10, 1919
9. Birthplace (State or Foreign Country): North Car.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1918 N. Bentalou Street
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator
16b. Kind of Business/Industry: Baltimore City Public Schools

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): Elease Winston

19a. Informant's Name/Relationship (Type, Print): Donna J. Owens-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6890 N.C. Highway Yancyville N.C. 27379

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 01/29
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Herbert E. Nutter
22. Name and Address of Facility: Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy Balto. MD 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Joyce A. Owens

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ C. Kearney MD
29c. License number: D0027860
29d. Date signed (Month, Day, Year): JANUARY 29th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER D. KEARNEY 700 WASH. BLVD BALT MD 21230

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: ▶ Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Wilhelmine Plitt
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Forest Haven Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-74-1535
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1904
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 4211 Frederick Road
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Dieterich
18. Mother's Name (First, Middle, Maiden Surname): Louise Knoblock

19a. Informent's Name/Relationship (Type, Print): Dolores Stenner/ Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Stonewall Road, Catonsville, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 1/30/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. ATHEROSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of): DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D28595
29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a,b,c,d,PtII,30per Dr.G791,01/30/01dhb

Certificate of Death

Reg. No. 2001 02260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN P. PARHAM
2. Date of Death Month / Day / Yeer: 1 - 17 - 2001
3. Time of Deeth: 7 45 AM
4e. Facility Neme (If not institution, give street and number): Snow Hill Nursing & Rehab. Center, 430 W. Market ST
4b. City, Town, or Location of Death: Snow Hill, MD
4c. County of Death: Worcester
5. Social Security Number: 217224164
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/17/13
9. Birthplace (State or Foreign Country): MD.

Funeral Director

Usuel Residenca of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Snow Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 430 W. Market Street
10f. Zip Code: 21863
10g. Citizen of What Country?: USA
11. Maritel Status: 1☐ Never Merried 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: education
17. Father's Name (First, Middle, Last): Walter Francis Powell
18. Mother's Name (First, Middle, Maiden Surname): Ethel Mariner
19e. Informant's Name/Relationship (Type, Print): Pamela Hampton/niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 Parkway Ave Salisbury, MD 21804
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cauae on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypoxic Respiratory failure

Due to (or es a consequenca of): Hx Tuberculosis

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting tn deeth) Last

b.

Due to (or as e consequence of): Hx Congestive Heart Failure

c.

Due to (or es a consequence of): Hx Carcinoma of Breast

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert t.: Depression, Cachexia & Malnutrition, ~~Hx. of Cancer Breast~~; Multi infarct Dementia; ~~Hx. HTN~~

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physicisn:** To the best of my knowledge, death occurred et the time, date snd placa, snd due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, snd due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: Sarad
29c. License number: D-54422
29d. Dete signed (Month, Dey, Year): 1-18-01

30. Name snd address of person who completed cause of death (Item 23a) (Type, Print): Sarad Baral, MD, Suite # 103, 500 Market Sts., Pocomoke, MD 21851

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001
32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vito J. Piccione
2. Date of Death — Month: January Day: 26 Year: 2001
3. Time of Death: 7:50pm
4a. Facility Name (If not institution, give street and number): Gilchrist Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-16-5486
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-17-1925
9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3912 Claremont Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Teledyne Energy Systems

17. Father's Name (First, Middle, Last): Carmine Piccione
18. Mother's Name (First, Middle, Maiden Surname): Cesira Graziaplena

19a. Informant's Name/Relationship (Type, Print): wife Concetta Polsinelli Piccione
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3912 Claremont St., Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus — Date: 1/30/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Marcia B. Zannino
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral HM 2633 S. Conkling Street, Baltimore, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. respiratory failure 2° to
Due to (or as a consequence of):
b. sepsis — days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. end-stage renal disease — weeks
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
coronary artery disease
diabetes mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: ▶ Brenda G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1/26/01 Vito Piccione 7pm 1/53

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Teresa Petr
2. Date of Death (Month, Day, Year): Jan 24 2001
3. Time of Death: 7:45 AM
4a. Facility Name (If not institution, give street and number): Perring Parkway Nursing Home
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-07-5513
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 9 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3802 Frankford Ave.
10f. Zip Code: 21206
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Charles Linzey
18. Mother's Name (First, Middle, Maiden Surname): Mary Bissler

19a. Informant's Name/Relationship (Type, Print): Mary Kozlosky sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7631 Daniels Ave. Baltimore, Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery | Date: Jan 27 2001
20c. Location - City or Town, State: Baltimore, Md
21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: EVANS Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Basal Cell Carcinoma	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martha C. Raymundo MD
29c. License number: 054518
29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

01-0388-510
jhm
NATHANIEL
PARKER JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nathaniel Parker Jr.
2. Date of Death (Month, Day, Year): JANUARY 24, 2001
3. Time of Death: 00:55 AM
4a. Facility Name (If not institution, give street and number): 1732 ST. PAUL STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-64-8575
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 13, 1958
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1732 St. Paul Street
10f. Zip Code: 21202
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Negro

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unemployed
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Nathaniel Parker Sr.
18. Mother's Name (First, Middle, Maiden Surname): Jacqueline Nicholson

19a. Informant's Name/Relationship (Type, Print): Mr. Nathaniel Parker Sr. (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 602 Wildwood Parkway Balto. Md. 21229

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 2/2/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Gunshot wound of head
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year): 1-24-2001
28b. Time of Injury: 0045 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Subject was shot
28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1732 St. Paul street Baltimore City, Maryland

29e. Certifier (Check only one): 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Stephen S. Radentz, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 8 PER F.H. G792 2-5-01 WR.

Certificate of Death

Reg. No. 2001 02264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNARD NORBERT ROZANSKI

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 4:10 PM

4a. Facility Name (If not institution, give street and number): Mariner Health Care of Catonsville

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-3037

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 70 ~~71~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 6, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 5832 Edmondson Ave.

10f. Zip Code: 21228

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No. If Yes, Give Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Warehouse Supervisor

16b. Kind of Business/Industry: School Supplies

17. Father's Name (First, Middle, Last): Albert Rozanski

18. Mother's Name (First, Middle, Maiden Surname): Helen Ziolkowska

19a. Informant's Name/Relationship (Type, Print): Stephen Rozanski/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5832 Edmondson Ave. Baltimore, Maryland 21228

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory Inc.

Date: 01/29

20c. Location - City or Town, State: Baltimore, Marylad

21. Signature of Funeral Service Licensee: ▶ Kathleen Weber CFSP

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic obstructive Pulmonary Disease — twelve hours.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sleep Apnea, Diabetes Mellitus, Atrial Fibrillation, Arthritis

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edmund P. Tkaczuk MD

29c. License number: D34451

29d. Date signed (Month, Day, Year): 1-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edmund P. Tkaczuk 405 Frederick Rd Suite 100 Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: ▶ Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02265

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BETTY R. RETTEW

2. Date of Death Month / Day / Year: JAN. 24 2001

3. Time of Death: 1:18 PM

4a. Facility Name *(If not institution, give street and number)*: Blakehurst Life Care Community

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-14-0373

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5-26-1922

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1055 W. Joppa Rd.

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaking-Own Home

17. Father's Name *(First, Middle, Last)*: Harry Spiekerman

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Baxter

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Bonnie Rettew (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 300 Gailridge Rd. Timonium, Maryland 21093

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley M. G. Data: 1-27-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Donald C. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Congestive Heart Failure — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Asthma Stroke

Glaucoma

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell

29c. License number: D42129

29d. Date signed *(Month, Day, Year)*: 1-25-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William McConnell 500 W. University Baltimore 21210

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Bonnie B Sparks

FEB 1 2001

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

JS

2001 JAN 30 AM 1:29

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith C. Routh
2. Date of Death — Month: January Day: 21 Year: 2001
3. Time of Death: 5:30 P.M.
4a. Facility Name (If not institution, give street and number): Future Care of the Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217 82 2433
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 3, 1913
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1222 Sedge Court
10f. Zip Code: 21122
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Alfred Turner
18. Mother's Name (First, Middle, Maiden Surname): Dora Hale

19a. Informant's Name/Relationship (Type, Print): Mike Routh / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 Sedge Court Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cramatory or other place): Glen Haven Memorial Park
Date: 1/24/01
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Bramiewski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. cerebrovascular accident — hours
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: advanced dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
26a. Date of Injury (Month, Day, Year)
26b. Time of Injury M
26c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how Injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D41955
29d. Date signed (Month, Day, Year): 1-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Elon 479 Jumpers Hole Rd #304 Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature:

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Karen Sherman

2. Date of Death: Month January Day 27 Year 2001

3. Time of Death: 21:01

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-66-5476

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 13, 1950

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1739 E. Fairmount Avenue

10f. Zip Code: 21231

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker

16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): Charles Edmund Sherman

18. Mother's Name (First, Middle, Maiden Surname): Ina Caroline Rudd

19a. Informant's Name/Relationship (Type, Print): Ina Caroline Sherman/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1739 E. Fairmount Ave. Baltimore, MD 21231

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 1/30/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia — 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Community acquired pneumonia — 8 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Todd Puleeritz M.D.

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TODD Puleritz 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0431-510
DOROTHY
SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Mae Smith

2. Date of Death Month Day Year: JANUARY 25, 2001

3. Time of Death: 10:30P.M.

4a. Facility Name (If not institution, give street and number): 2702 KEYWORTH AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 215-24-4590

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1-18-1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2702 Keyworth Ave Apt 3

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): Unknown

College (1-4or 5+): Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Robert Dunton

18. Mother's Name (First, Middle, Maiden Surname): Mildred Mills Dunton

19a. Informant's Name/Relationship (Type, Print): Dorothy Napier (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10069 Cotton Mills La., Columbia, Md.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place): Druid Ridge Cem. Date: 1/30/01

20c. Location - City or Town, State: Pikesville, Md

21. Signature of Funeral Service Licensee: Lewis T Gwynn

22. Name and Address of Facility: Lewis T. Gwynn Funeral Home 4517 Park Heights Ave Balto. Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check Only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Carlon Locke, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Carlon Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Lawrence G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02269

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: RUSSELL STATEN

2. Date of Death Month: January Day: 24 Year: 2001

3. Time of Death: 0239

4a. Facility Neme *(If not institution, give street end number)*: UNION MEMORIAL

4b. City, Town, or Location of Death: BALTO

4c. County of Death:

Funeral Director

5. Social Security Number: 214-62-8657

6. Sex: 1☑ M 2☐ F

7. Age *(In yrs. last birthday)*: 45 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 0624 55

9. Birthplece *(Stete or Foreign Country)*: VIRGINIA

Usuel Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 821 N. MONTFORD AVE

10f. Zip Code: 21205

10g. Citizen of What Country?: US

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondary (0-12): 12+H; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CHEF

16b. Kind of Business/Industry: RESTAURANT

17. Father's Neme *(First, Middle, Last)*: LEE SKIPPER

18. Mother's Neme *(First, Middle, Meiden Surnema)*: MATTIE SUE STATEN

19a. Informent's Neme/Reletionship *(Type, Print)*: BROTHER NATHANIEL STATEN

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 821 N. MONTFORD AVE.

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: BAY VIEW CREMATORY Date: 01/29/01

20c. Location - City or Town, Stete: BALTO, MD

21. Signetura of Funaral Service Licensee: Wesley [illegible]

22. Name and Address of Facility: CHAVIS FUNERAL HOME 2007 EASTERN AVE BALT, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daeth. Do not anter the mode of dying, such es cardiac or respiretory arrast, shock, or heert failura. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immedlete Cause (Finel disaasa or condition resulting in deeth): e. Sepsis — 1 day

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Diseese or Injury thet initieted events rasulting in death) Last:

b. End Stage Renal Disease — 5 years

Dua to (or as a consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cauee of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Ware autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: Watson, M.D.

29c. License number: AT 2438946

29d. Dete signed *(Month, Dey, Year)*: January 24, 2001

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): Deborah Watson, M.D. Union Memorial Hospital 201 E. University Parkway, Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 30 2001

32. Registrar's Signeture: Jeanne B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02270

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eleanor Shackelford

2. Date of Death — Month: January; Day: 25; Year: 2001

3. Time of Death: 9:10 AM

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-07-3903

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 13, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 602 Oakclean Rd.

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 yrs.; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Packer

16b. Kind of Business/Industry: Manufacturing Co.

17. Father's Name *(First, Middle, Last)*: Louis Milchling

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Koch

19a. Informant's Name/Relationship *(Type, Print)*: Roger Shackelford (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2518 Pleasantville Rd. Fallston, Md. 21047

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Pk. Cem.

Date: 1-27-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. J. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home, 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	One Week
Due to (or as a consequence of): b.	Osteomyelitis	One Month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Stage Four Thoracic Decubitus Ulcer	One Month
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony C. Tamburello, III, MD

29c. License number: RES-001

29d. Date signed *(Month, Day, Year)*: January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony C. Tamburello, III, MD Johns Hopkins Bayview Medical Center

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Bernice G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 8 PER F.H. G791 1-30-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia M. Stewart
2. Date of Death (Month, Day, Year): Jan 22 2001
3. Time of Death: 6:25AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-01-2794
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~92~~ AUG 3, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 304 N. Ridge Road Apt. H-207
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Finance Administrator
16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middle, Last): Frederick Leigh Mortimer
18. Mother's Name (First, Middle, Maiden Surname): Anna Eleanor Krauss

19a. Informant's Name/Relationship (Type, Print): James P. Swing, III Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5026 Orchard Drive; Ellicott City, Maryland 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Cokesbury Cemetery
Date: 1/25/01
20c. Location - City or Town, State: Abingdon, Maryland

21. Signature of Funeral Service Licensee: J. A. Hay
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cerebrovascular Accident — 8 DAYS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Abeda Ali Khan M.D.
29c. License number: D43323
29d. Date signed (Month, Dey, Year): Jan 22 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): ABEDA ALI KHAN 10794 Hickory Ridge Road columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
RUTH	CATHERINE	SCHILLINGER	JANUARY 28, 2001	3:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-46-6624	1☐ M 2☒ F	82 Yrs.			AUG. 10, 1918	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	SEVERN	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8029 NEW CUT ROAD	21144	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Dates:	1☐ Yas 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother'a Name (First, Middla, Maiden Sumama)
HENRY R. WADE	CATHERINE R. DUVALL

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAMES D. SCHILLINGER, SR. (SON)	8065 NEW CUT ROAD, SEVERN, MARYLAND 21144

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stata
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) ENTOMBMENT	GLEN HAVEN MEMORIAL PARK	JAN. 31, 2001	GLEN BURNIE, MD.

21. Signature of Funeral Service licensee ▶ David D. Hulle M00305

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Aspiration pneumonia — one day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other eignificant conditione** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease
old my ocardial infarction

23b. **Did tobacco use contribute to the cauee of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion ot cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was casa referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceusa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D 18508	Jan. 29, 2001

30. Name ene address of person who completed cause of death (Item 23a) (Type, Print)
Charles J Wurm / 600 S. Crain Hwy Glen Burnie Md. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 30 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Saxon
2. Date of Death — Month: January Day: 24 Year: 2001
3. Time of Death: 9:38 pm
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 213-14-4815
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12.05.21
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 621 S. Linwood Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Frank Terence
18. Mother's Name (First, Middle, Maiden Surname): Laura Modrak

19a. Informant's Name/Relationship (Type, Print): Patricia Robey Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Blue Bell Ct. Port Deposit 21904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cem
Date: 1.29.01
20c. Location - City or Town, State: Baltimore Co., Md.

21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: Kaczorowski Funeral Home, P.A. 1301 Dundalk Ave 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cardiogenic shock	48 hours
Due to (or as a consequence of):	b. myocardial infarction	48 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. atherosclerosis	5 years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Wilson MD
29c. License number: AT 243946 A9
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Wilson 201 East University Parkway Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
MAURICE	SOPHER	JANUARY 25, 2001	2:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LEVINDALE HEBREW HOME	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-32-5699	1 X M 2 ☐ F	96 Yrs.			APR. 14, 1904	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2412 EVERTON ROAD	21209	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5+		OWNER	SOPHER CIGAR COMPANY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SAMUEL SOPHER	JENNIE SAPPERSTEIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SUSAN LEVINE / DAUGHTER	6606 CHELWOOD ROAD - BALTIMORE, MD 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CHIZUK AMUNO ARLINGTON	1/28/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Dementia	year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D35943	1/25/2001

30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

Susan N Levine Levindale

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 30 2001	[signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennie Stitzel

2. Date of Death: Month January Day 20 Year 2001

3. Time of Death: 9.21PM

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215 24 8139

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 31, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 204 W. Arundel Road

10f. Zip Code: 21225

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Warner Rogers Hazlegrove

18. Mother's Name (First, Middle, Maiden Surname): Bertha Frances Beale

19a. Informant's Name/Relationship (Type, Print): Bonnie Lynn Stitzel / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 W. Arundel Road Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 1/24/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerome Zramiewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bacterial peritonitis — 9 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease, respiratory failure, Diverticulosis, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mohamad Bakleh MD

29c. License number: RES000

29d. Date signed (Month, Day, Year): 01/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohamad Bakleh, MD 3001 S. Hanover street, Baltimore, MD 21225

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001

32. Registrar's Signature: Bernice B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #10F PER F.H. G791 1-30-01 WR:

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES STACEY
2. Date of Death: Month 1 Day 25 Year 2001
3. Time of Death: 5:20 AM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE MD
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217 05 8481
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 108 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/18/1892
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1535 N APPLETON STREET
10f. Zip Code: ~~21225~~ 21217
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tailor
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Green Stacey
18. Mother's Name (First, Middle, Maiden Surname): Betty Lindsey

19a. Informant's Name/Relationship (Type, Print): (wife) Mrs. Carrie Stacey
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1535 N. Appleton St. Balto. Md. 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens Date: 1/31/2001
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE GASTRO INTESTINAL BLEEDING	HOURS
Due to (or as a consequence of): b.	BLEEDING DIVERTICULUM	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CA OF PROSTATE ; CEREBROVASCULAR ACCIDENT ; DECUBITI

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Janet V. Mogharbel, MD
29c. License number: D14949
29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET V. MOGHARBEL, MD BON SECOURS HOSPITAL 2000 W. BALTIMORE ST. BALTIMORE MD 21223

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

FEE : ----

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEWIS WILLIAMS

2. Date of Death: Month Jan Day 27 Year 2001

3. Time of Death: 7:52pm

4a. Facility Name (If not Institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 254-40-0962

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 30 1932

9. Birthplace (State or Foreign Country): GA.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 633 AISQUITH ST.

10f. Zip Code: 21202

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GARDENER

16b. Kind of Business/Industry: LANDSCAPING-GARDENING

17. Father's Name (First, Middle, Last): UNK

18. Mother's Name (First, Middle, Maiden Surname): CORA SMITH

19a. Informant's Name/Relationship (Type, Print): EDWARD WILLIAMS/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45535 FOUNTAINVIEW DR. CANTON, MI 48188

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PINEDALE

Date: 2/3/2001

20c. Location - City or Town, State: PIEDMONT, SC

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 10min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edmond [illegible]

29c. License number: D38956

29d. Date signed (Month, Day, Year): Jan 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Seidel, 5601 Loch Raven Blvd., Baltimore, Maryland 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: [illegible] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit [illegible]

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02278

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS JACKSON WHITE
2. Date of Death Month Day Year: January 27, 2001
3. Time of Death: 5:45PM
4a Facility Name *(If not institution, give street and number)*: CATONSVILLE COMMONS
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-01-7978
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/ 25/ 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1 Woodlawn Ave.
10f. Zip Code: 21228
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: Home Improvement

17. Father's Name *(First, Middle, Last)*: Martin L. White
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Bolling

19a. Informant's Name/Relationship *(Type, Print)*: Bill White/ Nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 Woodlawn Ave. Baltimore, Maryland 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Louden Park Cemetery — Date: 02/01/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Kathleen Weber CFSP
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — W/C
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA, ATHEROSCLEROTIC ASCVD

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K.M. Mize MD
29c. License number: D20333
29d. Date signed *(Month, Day, Year)*: 1/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. MIZE MD 1838 GREENTREE RD PIKESVILLE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: ▶ Bernice G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02279

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES WALSH
2. Date of Death Month: JANUARY Day: 23 Year: 2001
3. Time of Death: 4.00 AM
4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-6370
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 7, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3420 Gaither Road
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Master Electrician
16b. Kind of Business/Industry: General Motors

17. Father's Name *(First, Middle, Last)*: James Henry Walsh
18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Ethel Althoff

19a. Informant's Name/Relationship *(Type, Print)*: Deborah Loveland Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3011 Wheatfield Road; Finksburg, Maryland 21048

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery
Date: 1/17/01
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MASSIVE ASPIRATION
Due to (or as a consequence of):
b. GASTROINTESTINAL BLEED

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Joginder P Mehta M.D.
29c. License number: D0041410
29d. Date signed *(Month, Day, Year)*: January 24th, 2001
30. Name and address of person who completed cause of death (item 23a) (Type, Print): JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

85

12+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02280

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lucille B Wysocki
2. Date of Death Month Day Year: JANUARY 28, 2001
3. Time of Death: 1:50 PM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-03-4042
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 24 1908
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8321 Old Harford Rd
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 3; College (1-4or 5+): —
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: factory worker
16b. Kind of Business/Industry: Continental Can
17. Father's Neme *(First, Middle, Last)*: John Baranoski
18. Mother's Name *(First, Middle, Maiden Sumame)*: Mariann Holowinski
19a. Informent's Neme/Reletionship *(Type, Print)*: Sandra Colaianni
19b. Melting Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8321 Old Harford Rd. Baltimore, Md 21234
20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Evans Funeral Chapel-Belair
Dete: Jan 30 2001
20c. Location - City or Town, Stete: Forest Hill, Md
21. Signature of Funeral Service Licensee: ▶ Linda S Wells
22. Name end Address of Fecility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Pärt I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Finat disease or condition resulting in deeth) a.	PNEUMONIA	12 DAYS
Due to (or es a consequence of):		
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last b.		
Due to (or es e consequence ol):		
c.		
Due to (or es a consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: MYOCARDIAL INFARCTION

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) and mennar as stated. 2☐ **Medical Examiner**: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner steted.

29b. Signeture and title of certifier: ▶ Joginder P Mehta M.D
29c. License number: D 0041410
29d. Date signed *(Month, Day, Year)*: January 29th, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrer's Signeture: ▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02281

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edith Marie Wilson

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 12:20 am

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-24-5670

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 09, 1914

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1013 Brantley Avenue

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Briseal

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Bessie Wilson-daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1013 Brantley Ave. Balto. MD 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: New Cathedral Cemetery

Date: 01/31

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: ▶ Herbert E. Nutter

22. Name and Address of Facility: Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac ARRhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.

29c. License number: P14583

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nischal Reddy, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: ▶ [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Edith Wilson

T

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Estelle Walters

2. Date of Death: Month January Day 26 Year 2001

3. Time of Death: 0530 a.m

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 079 20 2384

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 6, 1926

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1160 Ridge Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Businaas/Industry: Own Home

17. Father'a Neme (First, Middle, Last): Francis P. Scarano

18. Mother's Neme (First, Middle, Maiden Sumeme): Fillamina Buggi

19a. Informent's Neme/Reletionship (Type, Print): Robert Walters Jr. / Son

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 107 E. Chase Street Baltimore, Maryland 21202

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, crematory or other plece): Hilltop Service Corp.

Date: 2/2/01

20c. Location - City or Town, Stete: Towson, Maryland

21. Signeture of Funerel Service Licensee: Donna M Zramiowski

22. Neme end Address of Feclility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. pulmonary edema — 1 month

Due to (or es e consequence of):

b. congestive heart failure — 30 days

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that intieted events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contributa to the cauaa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion ot ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one)

Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(a) and manner steted.

29b. Signeture and title of certifier: Julia Presti DO

29c. License number: AT2438946

29d. Date signed (Month, Day, Year): 1/26/01

30. Nema and addrass ot person who completed ceuse of death (Item 23a) (Type, Print): JULIA PRESTI DO UNION MEMORIAL HOSPITAL, BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001

32. Registrer's Signeture: penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WAYNE WEYGANT

2. Date of Death — Month: JANUARY Day: 29 Year: 2001

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street and number): Northwest Hospital

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214 38 8759

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 25, 1940

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 26 Kenmar Avenue

10f. Zip Code: 21117

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician

16b. Kind of Business/Industry: Computers

17. Father's Name (First, Middle, Last): Clifford D. Weygant

18. Mother's Name (First, Middle, Maiden Surname): Ruth Miller

19a. Informant's Name/Relationship (Type, Print): Barbara Weygant / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 Kenmar Avenue Owings Mills, Maryland 21117

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Date: 1/30/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zromiowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: GIB, Anemia, liver failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D41500

29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.J. IMPERIAL, JR. MD — NWH.

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02284

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Nelson Waters Sr.
2. Date of Death Month / Day / Year: January 27, 2001
3. Time of Death: 8:00 AM
4a. Facility Name *(If not institution, give street and number)*: 3414 Trainor Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-03-3892
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 24, 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3414 Trainor Ave.
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Afro-American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Public Utility

17. Father's Name *(First, Middle, Last)*: Greenwood Waters
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Plater

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Harry Waters (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3414 Trainor Ave. Balto. Md. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery | Date: 2/2/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC DYSRHYTHMIA
Due to (or as a consequence of):
b. CARDIOMYOPATHY
Due to (or as a consequence of):
c. ISCHEMIC CARDIAC DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TYPE 2 DIABETES MELLITUS
METASTATIC CANCER OF URINARY BLADDER
SIP CEREBRO VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: T Tomlin md
29c. License number: D30272
29d. Date signed *(Month, Day, Year)*: 1/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS S. MILLER 700 WASHINGTON BLVD BALTIMORE, MD. 21230

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02285

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael, V Yeager
2. Date of Death Month Day Year: Jan 26th 2001
3. Time of Death: 12:50 Pm
4a. Facility Name (If not institution, give street and number): Baltimore VA Hosprtal
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-52-6497
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 18, 1949
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1706 Oakleigh Court
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Floor Covering
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Daniel E. Yeager
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Michael

19a. Informant's Name/Relationship (Type, Print): Joanna M. Yeager/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1706 Oakleigh Court Baltimore, MD 21234

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory Inc.
Date: 1-27-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregory
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Invasive Aspergillosis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sunguk Jang, MD
29c. License number: P13381
29d. Date signed (Month, Day, Year): 1-26-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sung uk Jang 22. South Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

216-52-6497

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02286

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie E. Zivanovich

2. Date of Death Month: January Day: 28 Year: 2001

3. Time of Death: 6:15PM

4a Facility Name *(If not institution, give street end number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-14-7341

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 7, 1920

9. Birthplace *(State or Foreign Country)*: Parisburg, VA

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 3939 Roland Avenue Apt. 616

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Edcetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name *(First, Middle, Last)*: William Bird

18. Mother's Name *(First, Middle, Maiden Sumame)*: Nellie Willis

19a. Informent's Name/Reletionship *(Type, Print)*: Sandra Horner Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 615 S. Grundy Street Baltimore, MD 21224

20a. Method of Disposition: ☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Gardens of Faith

Dete: 2/1/01

20c. Location - City or Town, Stete: Fullerton, Maryland

21. Signature of Funerel Service Licensee: Jay H. Carpenter

22. Neme and Address of Fecility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval: 2½ months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Congestive Heart Failure, Cardio-myopathy, Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician**: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: E. S. Feen, MD

29c. License number: AT24389 46-A2

29d. Dete signed *(Month, Day, Year)*: January 28, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): E. S. Feen, UMH Dept of Medicine, 201 E. Unn Pkwy, Balto, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Jenna G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0135-019

GERALD ALDRIDGE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald William Aldridge
2. Data of Death Month: JANUARY Dey: 7, Year: 2001
3. Time of Death: 1:50P.M.
4a Facility Name (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 214-46-4989
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): May 7,1947
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Hurlock
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4712 Skeet Club Road
10f. Zip Code: 21643
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 [X] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indien, Bleck, Whita, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Sample Technician
16b. Kind of Business/Industry: B & P Pickle Company

17. Fether's Neme (First, Middle, Last): Ollie Smith, Jr.
18. Mother's Neme (First, Middle, Maiden Surneme): Lillian Aldridge

19a. Informent's Neme/Reletionship (Type, Print): Odessa Carter / Sister
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4712 Skeet Club Road, Hurlock,Maryland 21643

20a. Method of Disposition: 1 [X] Burlel 2 [ ] Cremation 3 [ ] Removei from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Petersburg Cemetery
Dete: 1/13/2001
20c. Location - City or Town, Stete: Hurlock,Maryland

21. Signeture of Funeral Service Licensee:
22. Name end Address of Fecility: Bennie Smith Funeral Home 426 Dover Street, Easton,Maryland 21601

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications thet caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. (Approximate Intervel Between Onset end Death)

Immediete Ceuse (Finel diseese or condition resulting in death):
a. Pulmonary Thromboembolli
Due to (or as a consequence of):
b. Deep Vein Thromboses
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or es e consequence of):
c. Fractured Right Tibia and Fibula
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death?: 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed?: 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death?: 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No
26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [ ] Netural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 12/22/00
28b. Time of Injury: UNK M
28c. Injury at Work? 1 [X] Yes 2 [ ] No
28d. Describe how injury occurred: Subject fell at work
28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify): Business
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): 4915 Harrison Ferry Rd. 21643

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) snd manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner steted.
29b. Signeture and title of certifier: [illegible] MD
29c. License number: O.C.M.E.
29d. Data signed (Month, Day, Year): JANUARY 9, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Allan Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrer's Signature: G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES ARMSTRONG

2. Date of Death: Month January Day 17 Year 2001

3. Time of Death: 4:50 AM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 041-46-5310

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 13, 1919

9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 928 Schooner Circle

10f. Zip Code: 21401

10g. Citizen of What Country? Canada

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Herbert John Elliott

18. Mother's Name (First, Middle, Maiden Surname): Ellen Harris

19a. Informant's Name/Relationship (Type, Print): Raymond Armstrong/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4301 Country Club Circle Virginia Beach, VA 23455

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 1/18/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Todd E. Liller

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTRACRANIAL HEMORRHAGE — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

PRIOR HISTORY OF INTRACEREBRAL HEMORRHAGE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D33577

29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTHONY CAPUTO 139 OLD SOLOMONS ISLAND RD ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Alfano, Jr.

2. Date of Death (Month, Day, Year): January 12 2001

3. Time of Death: 6:28 A.M.

4a. Facility Name (If not institution, give street and number): The John Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 036-36-3108

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 3, 1952

9. Birthplace (State or Foreign Country): RI

Usual Residence of Decedent

10a. State: MD

10b. County: Queen Anne's

10c. City, Town or Location: Chester

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2828 Cox Neck Road

10f. Zip Code: 21619

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sr. Vice President

16b. Kind of Business/Industry: Financial

17. Father's Name (First, Middle, Last): John Alfano, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Edith Buonacorsi

19a. Informant's Name/Relationship (Type, Print): Kathleen Alfano/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2828 Cox Neck Road, Chester, MD 21619

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Jan 16 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Allen

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Scleroderma — 10 years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Fibrosis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marcus Brown M.D.

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 12, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Marcus Brown, M.D. Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Dey, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02290

NAME KNOWN TO PHYSICIAN: ALLISON, PAUL M

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Merrimon Allison

2. Data of Death (Month, Day, Year): JANUARY 5, 2001

3. Time of Death: 7:35PM

4a Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 242-22-9845

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 4,1910

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Davidsonville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3251 Beards Point Road

10f. Zip Code: 21035

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas: 1943 to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Law Enforcement

17. Father's Name (First, Middle, Last): Benjamin Young Allison

18. Mother's Name (First, Middle, Maiden Surname): Bertie Jane Owens

19a. Informant's Name/Relationship (Type, Print): Tanje A. Sears (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3251 Beards Point Road Davidsonville, Maryland21035

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metropolitan Crematory | Date: 1/8/2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Beverly M. Sutton

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street, Annapolis, MD21401

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. CONGESTIVE HEART FAILURE — UNKNOWN

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:

b. Dua to (or as a consequenca of):

c. Dua to (or as a consequance of):

d.

Part II. **Other signifcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D52739

29d. Date signed (Month, Day, Year): JANUARY 5, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

JAN 0 9 2001

01-0206-045
CJ
Donald Albert Brittingham

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Albert Brittingham
2. Date of Death: Month: January; Day: 12; Year: 2001
3. Time of Death: 05:51 P.M.
4a. Facility Name (If not institution, give street and number): Peninsula Regional Medical Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 212-48-1707
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months; Days
If Under 24 Hrs.: Hours; Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1949
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Wicomico
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9076 Bi State Blvd.
10f. Zip Code: 21875
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Housing
17. Father's Name (First, Middle, Last): Curtis A. Brittingham
18. Mother's Name (First, Middle, Maiden Surname): Virginia Morris Brittingham
19a. Informant's Name/Relationship (Type, Print): Virginia Brittingham, Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30071 Harris Lane, Delmar, Md. 21875
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Garden
Date: 1-17-2001
20c. Location - City or Town, State: Hebron, Md.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 1/2/01 FOUND

28b. Time of Injury FOUND: 1700 PM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: DRIVER OF VEHICLE WHICH STRUCK A FIXED OBJECT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State): RT 346, PITTVILLE MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIBBLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES OTTEN BALDWIN

2. Date of Death: Month Jan. Day 12 Year 2001

3. Time of Death: 9:30 AM

4a. Facility Name (If not institution, give street and number): 3233 Harney Road

4b. City, Town, or Location of Death: Taneytown

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-03-1795

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 26, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3233 Harney Road

10f. Zip Code: 21787

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic

16b. Kind of Business/Industry: Automobile

17. Father's Name (First, Middle, Last): Wilbur Baldwin

18. Mother's Name (First, Middle, Maiden Surname): Christiana Lilly

19a. Informant's Name/Relationship (Type, Print): Peggy Roland/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1250 Hughes Shop Rd., Westminster, MD 21158

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: 01/13

20c. Location - City or Town, State: Smithsburg, MD 21783

21. Signature of Funeral Service Licensee: John M. Skiles MO0534

22. Name and Address of Facility: Skiles Funeral Home, 136 E. Baltimore St., Taneytown, MD 21787

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RESPIRATORY FAILURE	MINUTES
Due to (or as a consequence of): b.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	CORONARY ARTERY DISEASE	MONTHS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MYELOPROLIFERATIVE DISORDER

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald Krabill MD

29c. License number: MD0015676 PA

29d. Date signed (Month, Day, Year): 01-12-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RONALD KRABILL MD 423 S. WASHINGTON ST. GETTYSBURG PA 17325

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #14 per FHG792 2/16/2001 EW

Certificate of Death

Reg. No. 2001 02293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Eleanora Brown

2. Date of Death: Month January Day 13 Year 2001

3. Time of Death: 4:01 AM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-12-1751

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 14, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Union Bridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2 Lehigh Dr.

10f. Zip Code: 21791

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: ~~White~~ Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): book sorter

16b. Kind of Business/Industry: book distribution co.

17. Father's Name (First, Middle, Last): Thomas Harpe

18. Mother's Name (First, Middle, Maiden Surname): Julia Butler

19a. Informant's Name/Relationship (Type, Print): Yvonne Gambrill/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3830 Elmcroft Rd. Randallstown, MD 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. James Cemetery

Date: 1/17/01

20c. Location - City or Town, State: New Windsor, MD 21776

21. Signature of Funeral Service Licensee: Connie L. Brothers

22. Name and Address of Facility: Hartzler Funeral Home, 6 E. Broadway Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiogenic Shock — 2 days

Due to (or as a consequence of):
b. Myocardial infarction — 2days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Acute renal Failure — 4days

Due to (or as a consequence of):
d. Sepsis — 2days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, Coronary art disease, Peripheral vascular disease.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Khan Freisi MD

29c. License number: D38915

29d. Date signed (Month, Day, Year): 1/15/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): FREISI 295 Stoner Ave Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02294

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy M Bureau

2. Date of Death Month: January Day: 5 Year: 2001

3. Time of Death: 5:00 Am

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 016-07-0027

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 16, 1906

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Massachusetts

10b. County: Franklin

10c. City, Town or Location: Greenfield

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 351 Federal Street

10f. Zip Code: 01301

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John A. Cardwell

18. Mother's Name (First, Middle, Maiden Surname): Victoria M. Paul

19a. Informant's Name/Reletionship (Type, Print): Michelina D. Hurd/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 312 Carriage Run Rd. Annapolis, MD 21401

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Calvary Cemetery

Date: 1-9-01

20c. Location - City or Town, State: Greenfield, Mass.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Systemic Sepsis — 24 hours

Due to (or as a consequence of):
b. Aspiration Pneumonia — 24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

Cerebrovascular Accident, Hypertension

Coronary Artery Disease, Atrial Fibrillation

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Steph J Katz

29c. License number: D38687

29d. Date signed (Month, Day, Year): 1/8/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): STEPHEN J KATZ, M.D Anne Arundel Medical Center ANNAPOLIS, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

JAN 09 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02295

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN M. BROWN
2. Date of Death Month Day Year: JAN. 6 2001
3. Time of Death: 5:50 am
4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215-28-7673
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 21 1911
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 800 CARROLLTON AVENUE
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th | College (1-4 or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE
16b. Kind of Business/Industry: CROWNSVILLE STATE HOSPITAL

17. Father's Name *(First, Middle, Last)*: WASHINGTON PARKER
18. Mother's Name *(First, Middle, Maiden Surname)*: MARTHA JOHNSON

19a. Informant's Name/Relationship *(Type, Print)*: MADELINE M. JOHNSON (FRIEND)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 800 CARROLLTON AVE. ANNAPOLIS, MD. 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HOPE CHURCH CEMETERY | Date: 1/12/01
20c. Location - City or Town, State: EDGEWATER, MD.

21. Signature of Funeral Service Licensee: ▶ Harry D. Reese M00482
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hypernatremia	2 days
Due to (or as a consequence of):	Dehydration	1 wk
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):	Cerebrovascular accident	2M
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D32036
29d. Date signed *(Month, Day, Year)*: 1/6/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary J Sprague 2108 A Donald Ave Chester MD 21619

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02296

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley M. Breller

2. Date of Death (Month, Day, Year): JANUARY 14, 2001

3. Time of Death: 9:25 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 051-24-0254

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 7 1928

9. Birthplace *(State or Foreign Country)*: NY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County: Carroll

10c. City, Town or Location: Marriottsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2420 Henson Drive

10f. Zip Code: 21104

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: real estate salesperson

16b. Kind of Business/Industry: real estate

17. Father's Name *(First, Middle, Last)*: Ewald Kuehlewind

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Denz

19a. Informant's Name/Relationship *(Type, Print)*: Allan P. Breller (spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2420 Henson Dr., Marriottsville, Md 21104

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Alphonsus Cemetery

Date: 1/19/01

20c. Location - City or Town, State: Woodstock, MD

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END-STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D30263

29d. Date signed *(Month, Day, Year)*: 1-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KHOO M.D., 7620 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: ▶ Donna G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE MELVIN CALLAHAN

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 1807

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 225-28-5870

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 21, 1926

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: PARSONSBURG

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 32781 DAGSBORO RD

10f. Zip Code: 21849

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COMPUTER SCIENTIST

16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): REVEL FRANKLIN CALLAHAN

18. Mother's Name (First, Middle, Maiden Surname): MARGARET VANCE ROBEY

19a. Informant's Name/Relationship (Type, Print): KATHERINE A. CALLAHAN - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32781 DAGSBORO RD PARSONSBURG, MD 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PRESBYTERIAN CEMETERY

Date: 1/19/01

20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee: B. Keith Rhynard CFSP

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NON Ketotic Hyperosmolar Diabetic State — 3d

Due to (or as a consequence of):

b. Acute GASTROENTERITIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Recent & Acute CVA

COPD

ASCVD

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul R Fleury

29c. License number: D24872

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL R FLEURY MD 305 TENTH ST POCOMOKE CITY MD

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

225-28-5870

Lawrence Callahan

11+1VA DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended#10c,28a,01-16-01,WCHD,DQ **Certificate of Death** Reg. No. 2001 02298

William Cash 494 09 9796

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
WILLIAM LEE CASH	Jan	14	2001	2010

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
424-09-9796	1☒ M 2☐ F	79 Yrs.					DEC. 12, 1921	ALABAMA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DELAWARE	~~SUSSEX~~ SUSSEX	SEAFORD	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
518 NORTH WILLEY STREET	19973	AMERICA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12YRS.		ACCOUNTANT	MANUFACTURING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CLYDE WILLIAM CASH	EULA LEE MOSES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ALVAH F. CASH	518 N. WILLEY STREET SEAFORD, DELAWARE 19973

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ODD FELLOWS CEMETERY	1/18/01	SEAFORD, DELAWARE

21. Signature of Funeral Service Licensee: Lloyd W. Yates

22. Name and Address of Facility: WATSON-YATES FUNERAL HOME, INC. SEAFORD, DELAWARE 19973

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Brain Injury	6days
Due to (or as a consequence of):	b. Acute Subdural Hematoma	"
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Fall	"
Due to (or as a consequence of):	d. Seizure	"

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiinfarct dementia with porencephaly

Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined	~~01-08-2001~~ 01-08-2001	8:10 P M	1☐ Yes 2☑ No	Fall at home 2° seizure

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	518 N. Willey St Seaford DE

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
DO. DME	H50497	1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chris Snyder · 106 Milford St. suite 201 Salisbury, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

23a 1 SDA DQ

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#1, (per MD), Talbot, SRR, 01-08-01

Certificate of Death

Reg. No. 2001 02299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Walter Warner Cook~~ Walter Warner Cook

2. Date of Death: Month Jan. Dey 3 Year 2001

3. Time of Death: 11:16am

4a Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 220-32-0979

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): JAN 2, 1907

9. Birthplece (State or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD

10b. County: TALBOT

10c. City, Town or Location: OXFORD

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 101 HIGH STREET

10f. Zip Code: 21654

10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, Whita, etc. Specify: WHITE

15. Decedent'a Educetion (Specify only highest grade completed): Elementary/Secondery (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): WATERMAN

16b. Kind of Business/Industry: SEAFOOD

17. Father's Neme (First, Middle, Last): UNKNOWN

18. Mother's Neme (First, Middle, Meiden Surneme): GILETTA COOK

19a. Informent's Neme/Reletionship (Type, Print): ANN C. STEWART/DAUGHTER

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8699 MULLETT BRANCH RD, EASTON, MD 21601

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): OXFORD CEMETERY

Dete: 1-08-01

20c. Location - City or Town, Stete: OXFORD, MD

21. Signature of Funerel Service Licensee: M. E. Newnam III CFSP

22. Name and Address of Feciility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in death)

a. Acute Cardiac Arrest — minutes

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

b. Coronary Artery Disease — 2 years

Due to (or es e consequence of):

c. Arteriosclerotic Cardiac Disease — 10 years

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Prostate Carcinoma

Anemia of Chronic Disease

Chronic Bronchial Asthma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: Robert M. McDonald, MD

29c. License number: D 090 24

29d. Date signed (Month, Day, Year): 1/3/2001

30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print): Robert M. McDonald, MD, 30 Dover St. Easton, MD 21601

State Registrar

31. Dete filed (Month, Dey, Year): JAN 0 8 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

COOK, WALTER

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED, Item#31, per TCHD, 01/08/01, sbb

Certificate of Death

Reg. No. 2001 02300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Orion	Early	Crocker	Jan	4	2001	1845

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
231-12-4227	1 [X] M 2 [ ] F	76 Yrs.					June 25, 1924	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Caroline	Federalsburg	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
212 Maple Ave.	21632	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Janitor	Apartment Complex

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Early Unknown	Mary Crocker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rhonda Cain / niece	212 Maple Ave., Federalsburg, Maryland 21632

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Cambridge Crematory	1/8/2001	Cambridge, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bilateral Pneumonia	5 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

Gram positive Bacteremia

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD Staff Physician	D50325	1/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James F. Elmore, M D , 219 South Washington Street, Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
~~JAN 8 2001~~ JAN 0 8 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Orion Crocker

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02301

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM McCLELLAN COLE

2. Data of Death (Month, Dey, Year): January 9, 2001

3. Time of Death: 2155

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 153-22-1918

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): Jan. 27, 1932

9. Birthplaca (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Talbot

10c. City, Town or Location: St. Michaels

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 24481 Rolles Range Rd.

10f. Zip Code: 21663

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Army Korea

13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Raca - American Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grada completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Dept. of Defense

16b. Kind of Business/Industry: Federal Govt.

17. Father's Neme (First, Middle, Last): William Cole

18. Mother's Neme (First, Middle, Meiden Surneme): Mary L. Johnson

19a. Informent's Neme/Relationship (Type, Print): Donna L. Cole Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 748 St. Michaels, Maryland 21663

20a. Mathod of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or othar piece): Eastern Shore Maryland Veterans Cemetery

Dete: 1-12-01

20c. Location - City or Town, Stete: Hurlock, Maryland

21. Signature of Funeral Service Licensee: Harrison E. Leonard

22. Neme end Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Pert1. Enter the diseesa, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximate interval Between Onsat end Death

Immediate Cause (Final diseese or condition resulting in deeth): a. Small cell lung carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other signifficant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicaf examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: David H Smith

29c. License number: D29887

29d. Date signed (Month, Day, Year): 1/10/00

30. Name and address ot person who completed cause of death (Item 23a) (Type, Print): David Smith M.D. 29466 Pintail Dr. Easton, Maryland 21601

State Registrar

31. Data filed (Month, Day, Year): JAN 11 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

William Cole

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

SBB

ADH
TIMOTHY T. COSTLEY
01-0304-013
AMENDED ITEMS# 23,27,& 28a-f per ME G792 022201 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Timothy T. Costley
2. Date of Death (Month, Day, Year): JANUARY 18, 2001
3. Time of Death: 2000 PM
4a. Facility Name (If not institution, give street and number): 301 EAST MAIN STREET
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 216-83-5660
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 3 1963
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 63 Charles Street
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction
16b. Kind of Business/Industry: Reeds Construction

17. Father's Neme (First, Middle, Last): Howard F. Costley Sr
18. Mother's Neme (First, Middle, Meiden Sumeme): Mary Jane Gibson

19a. Informent's Neme/Relefionship (Type, Print): Mary Jane Costley/mother
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 63 Charles Street Westminster, MD 21157

20a. Method of Disposition: 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from Stafe 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Fairview Cemetery
Dete: 1/23/2001
20c. Location - City or Town, Stete: Taylorsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme and Address of Fecility: Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD21157

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in death): a. NARCOTIC INTOXICATION AND PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due fo (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 X Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Wes case referred to medical examiner? X 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospitel: 1 ☐ Inpafient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify): AT SCENE

27. Manner of Death: 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 X Could not be determined

28a. Date of Injury (Month, Day Year): found: 1-18-01
28b. Time of Injury: found: 6:30 P M
28c. Injury at Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred: unknown
28e. Piece of Injury - At home, farm, atreet, factory, office building, etc. (Specify): found in apartment
28f. Location (Street end Number or Rurel Route Number, City or Town, State): 301 E. Main, #10, Westminster, MD

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
X ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature], MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 19, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JAN 22 2001
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02303

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Olive T. Cullison
2. Date of Death — Month: January; Day: 11; Year: 01
3. Time of Death: 11:30pm
4a. Facility Name *(If not institution, give street and number)*: Copper Ridge
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-14-8694
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 26, 1925
9. Birthplace *(State or Foreign Country)*: Colorado

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 710 Obrecht Road
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12); College (1-4or 5+): 6
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Oscar Theodore Jones
18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Burke

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Scott M. Cullison (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7888 Hammond Pkwy Laurel, MD 20723

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All County Cremation Srv. — Date: 1/13/01
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Brian D. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia — weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ernestine Wright, MD
29c. License number: DS2740
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ernestine Wright, Copper Ridge, 710 Obrecht Road, Sykesville MD 21784

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ANNE DAVIS

2. Date of Death: Month JANUARY Day 12 Year 2001

3. Time of Death: 1340

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-74-3437

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 2, 1908

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 116 WALNUT STREET

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast greda completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JEPSEY PUSEY

18. Mother's Neme (First, Middle, Maiden Surneme): EMMA LEWIS

19a. Informant's Name/Retationship (Type, Print): VIOLA F. CULP - DAUGHTER

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1221 JOHNSON RD SALISBURY, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): WICOMICO MEMORIAL PARK

Date: 1/16/01

20c. Location - City or Town, State: SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee: ▶ B. Reyt Phynn, CFSP

22. Name and Addrass of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

MARY DAVIS 215-74-3437

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE PNEUMONIA — 15 DAYS

Due to (or es a consequence of): DEMENTIA — 2 YEARS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

MALNUTRITION

CACHEXIA

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ for [illegible], MD

29c. License number: D 46962

29d. Date signed (Month, Day, Year): JANUARY 13, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): M. SHIRAZI, M.D. ATTENDING PHYSICIAN. PENINSULA REGIONAL MEDICAL CENTER SALISBURY. MD 21081.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4 DQ

State Registrar

31. Data filed (Month, Dey, Year): JAN 16 2001

32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per Phy. 01/23/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Lou Day

2. Date of Death: Month Jan, Day 16, Year 2001

3. Time of Death: 2:50am

4a. Facility Name (If not institution, give street and number): 604 Poole Road

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-20-0426

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 4 1927

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 480 Avenel Circle

10f. Zip Code: 21158

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Principal

16b. Kind of Business/Industry: Public School System

17. Father's Name (First, Middle, Last): Benjamin Harrison Day

18. Mother's Name (First, Middle, Maiden Surname): Ninnasau Hughes

19a. Informant's Name/Relationship (Type, Print): Patty Zepp/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 604 Poole Road Westminster, MD 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Carroll Cremation, Inc Date: 1/17/2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD21157

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death) a. Lung cancer — one yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: None Known

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Niece's Residence

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☑ ~~Residence~~ 6☒ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: ▶ Howard Saiontz, M.D.

29c. License number: Md. # D15552

29d. Date signed (Month, Day, Year): 1/16/01

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): Howard Saiontz M.D. 555 S. Center St. Westminster, Md. 21157

State Registrar

31. Dete filed (Month, Dey, Year): JAN 17 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02306

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CARL EGBERT DALEY
2. Date of Death Month / Day / Year: Jan 9 2001
3. Time of Death: 2:00 PM
4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 169-16-8659
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 23,1920
9. Birthplace *(State or Foreign Country)*: NJ

Usual Residence of Decedent

10a. State: MD
10b. County: DORCHESTER
10c. City, Town or Location: HURLOCK
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 4210 RIDGE CREST RD
10f. Zip Code: 21643
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESMAN
16b. Kind of Business/Industry: HARDWOOD FLOORING

17. Father's Name *(First, Middle, Last)*: CHARLES DALEY
18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: IRIS G. DALEY/ WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4210 RIDGE CREST RD, HURLOCK, MD 21643

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR
Date: 01-10-01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Mann E Nelson III CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRIAON ST EASTON, MD 21601

Carl Daley
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. aspiration — weeks

Due to (or as a consequence of):
b. alzheimer dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: complete heart block
myelopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D25750
29d. Date signed *(Month, Day, Year)*: 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: Linda B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Clemens Davitt

2. Date of Death: Month January Day 15 Year 2001

3. Time of Death: 4:15 AM

4a. Facility Name (If not institution, give street and number): Annapolis Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 225-66-4248

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs. If Under 1 Year: Months Days If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): March 29,1903

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: VA

10b. County: Arlington

10c. City, Town or Location: Arlington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2717 S. Lang Street

10f. Zip Code: 22206

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): William Jesse Moorman

18. Mother's Name (First, Middle, Maiden Surname): Lena Maude Fricks

19a. Informant's Name/Relationship (Type, Print): Patricia D. Fisher/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1385 Stonecreek Road Annapolis, MD, 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hanna Cemetery

Date: 1-18-01

20c. Location - City or Town, State: Rising Fawn, Georgia

21. Signature of Funeral Service Licensee: ▶ C. Brian Powell

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D 0029571

29d. Date signed (Month, Day, Year): Jan. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Berez, M.D. 1655 Crofton Blvd, Rt. 3 Crofton, MD. 21114

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02308

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hilda H. Divver

2. Date of Death — Month: January Day: 11 Year: 2001

3. Time of Death: 9:04 A.M.

4a. Facility Name *(If not Institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-60-5397

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 11, 1913

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3673 First Avenue

10f. Zip Code: 21037

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Bureau of Engraving and Printing

17. Father's Name *(First, Middle, Last)*: Harry E. Payne

18. Mother's Name *(First, Middle, Maiden Surname)*: Martha F. Kidwell

19a. Informant's Name/Relationship *(Type, Print)*: Genevieve H. Horan/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3673 First Avenue Edgewater, Maryland 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery — Date: 1-15-01

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Septic shock	8 hrs.
Due to (or as a consequence of): b.	Urinary tract infection	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] G J Sprouse

29c. License number: D32036

29d. Date signed *(Month, Day, Year)*: 1/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary J. Sprouse, M.D. 2108 DiDonato Drive Chester, Maryland 21619

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Francis

2. Date of Death: Month 1 Day 8 Year 01

3. Time of Death: 20:40

4a. Facility Name (If not Institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-38-6019

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 17, 1931

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 144 Duval Lane

10f. Zip Code: 21037

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher's Aide

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Ernest Francis Allen

18. Mother's Name (First, Middle, Maiden Surname): Susie Kettner

19a. Informant's Name/Relationship (Type, Print): William J. Francis, II/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1424 Johns Avenue Hazleton, Pennsylvania 18201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington Natl. Cemetery | Date: 1-16-01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease ten years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobecco use contributs to the causs of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D51819

29d. Date signed (Month, Day, Year): 1/09/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Matthew Malta, M.D. 1833 A. Forest Drive Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Titus Roosevelt Gattis

2. Date of Death: Month: January Day: 12 Year: 2001

3. Time of Death: 0603

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-18-4480

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 19 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 832 Larch Way

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yes, Give Yaar or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Ernest Ware Gattis

18. Mother's Name (First, Middle, Maiden Surname): Emma Dashiell

19a. Informant's Name/Relationship (Type, Print): Gwynell Elsey (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 832 Larch Way Salisbury, Md. 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Head Of Creek Cemetery Date: 1/20/01

20c. Location - City or Town, State: Quantico, Md.

21. Signature of Funeral Service Licensee: Earl M. Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hypothermia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. sepsis

Due to (or as a consequence of):

c. dementia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, offica buiiding, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: Nathan MD

29c. License number: D47094

29d. Date signed (Month, Day, Year): 1/12/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): NATHAN, MD 106 PINE BLUFF ROAD #12 SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Titus Gattis 215-18-4480

17 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Estella Graves

2. Date of Death (Month, Day, Year): January 01, 2001

3. Time of Death: 8:45 AM

4a. Facility Name (If not institution, give street and number): 6741 Church Lane

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 213-22-7189

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 21, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6741 Church Lane

10f. Zip Code: 21620

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Private Family

17. Father's Name (First, Middle, Last): William Dorn

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Graves

19a. Informant's Name/Relationship (Type, Print): Rader Steward / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 904, Chestertown, Maryland 21620

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Emmanuel Cemetery

Date: 1/6/2001

20c. Location - City or Town, State: Chestertown, Maryland

21. Signature of Funeral Service Licensee: John A. Prince

22. Name and Address of Facility: Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular accident	6 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. cerebrovascular disease	
Due to (or as a consequence of):		
	c. hypertension	
Due to (or as a consequence of):		
	d. coronary artery disease	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: urinary tract infection

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margaret D. Malaro

29c. License number: 0055727

29d. Date signed (Month, Day, Year): 1-04-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margaret D. Malaro 516 Washington Ave. Chestertown MD 21620

State Registrar

31. Date filed (Month, Day, Year): JAN 08 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SAB

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended Item #1, Per Phy., 01/11/2001, Carroll County, cew

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02312

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET CATHERINE GRIMES (Grimes)

2. Date of Death — Month: January; Day: 7; Year: 2001

3. Time of Death: 6:50AM

4a. Facility Name *(If not institution, give street and number)*: Glade Valley Nursing & Rehab. Center

4b. City, Town, or Location of Death: Walkersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-18-1380

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 1, 1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Walkersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9340 Links Rd.

10f. Zip Code: 21793

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: seamstress

16b. Kind of Business/Industry: clothing factory

17. Father's Name *(First, Middle, Last)*: Walter Rudolph Fogle

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Catherine Heffner

19a. Intormant's Name/Relationship *(Type, Print)*: Barbara Haines/ daughter

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 9340 Links Rd, Walkersville, MD 21793

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other pleca)*: Glade Cemetery

Date: 1/10/01

20c. Location - City or Town, State: Walkersville, MD

21. Signature of Funerel Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 404 S. Main St. Woodsboro, MD 21798

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic colon Cancer — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of cartifier: [signature] MD

29c. License number: 31075

29d. Date signed *(Month, Day, Year)*: 1/8/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Geo Ashe, 10200 Apperson Rd. Woodsboro, MD 21798

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 11 2001

32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02313

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETTAMAE GARVER

2. Date of Death Month Day Year: January 12, 2001

3. Time of Death: 2:40 PM

4a. Facility Name *(If not institution, give street and number)*: 103 Liberty Street

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-18-1908

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 12, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 103 Liberty Street

10f. Zip Code: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer/Husker

16b. Kind of Business/Industry: Canning Factory

17. Father's Name *(First, Middle, Last)*: John C. Tawney

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Rebecca Yingling

19a. Informant's Name/Relationship *(Type, Print)*: Doris Garber/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 103 Liberty St, Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Westminster Cemetery

Date: 1/15/01

20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: Robert A. Myers

22. Name and Address of Facility: Myers Funeral Home 91 Willis Street Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. ASCVD — 25yr

Due to (or as a consequence of):

b. Pneumonia — 2mon

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton

29c. License number: D25443

29d. Date signed *(Month, Day, Year)*: 1/13/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John W. Middleton M.D. 688 Poole Rd, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ettamae Garver

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Gorsuch, Jr.

2. Date of Death: Month Jan, Day 16, Year 2001

3. Time of Death: 5:00am

4a. Facility Name (If not institution, give street and number): 309 Melanchton Avenue

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-26-6653

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Aug 1 1929

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 309 Melanchton Avenue

10f. Zip Code: 21093-5301

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1952 1993

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Officer

16b. Kind of Business/Industry: Military

17. Father's Name (First, Middle, Last): George Willard Gorsuch

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Troxell Pool

19a. Interment's Name/Relationship (Type, Print): Eleanor Gorsuch/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 Melanchton Ave. Lutherville, MD 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Date: 1/19/2001

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatorenal failure — ~1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic colorectal cancer — ~2.5 years.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Chang MD

29c. License number: D16587

29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Chang, MD 5601 Loch Raven Blvd, Baltimore, MD 21239

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Gonda

2. Date of Death (Month, Day, Year): January 4, 2001

3. Time of Death: 3:01 P.M.

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-52-1422

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 28, 1910

9. Birthplace (State or Foreign Country): Hungary

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8505 Springvale Road, Apt. 24

10f. Zip Code: 20910

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): David Deutsh

18. Mother's Name (First, Middle, Maiden Surname): Charlotte Fayer

19a. Informant's Name/Relationship (Type, Print): Juliette G. Kragh/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3442 South River Terrace Edgewater, MD 21037

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 1-8-01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or compliceations thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert teilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. Acute Gastrointestinal Bleed — hours

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

b. Atherosclerotic Coronary Disease — years

Due to (or as a consequence of):

c. Congestive Heart Failure — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: [signature] and James DelVecchio MD

29c. License number: D44521

29d. Date signed (Month, Day, Year): 1/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James DelVecchio, M.D. 1500 Forest Glen Road Silver Spring, MD 20910

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02316

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LINDA CORTEZ GRAVES

2. Date of Death Month Dey Year: January 22, 2001

3. Time of Death: 6:08 PM

4a Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 150-38-4410

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: March 13, 1945

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Virginia

10b. County: Prince William

10c. City, Town or Location: Dale City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13313 Nassau Drive

10f. Zip Code: 22193

10g. Citizen of Whet Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yea 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: Julius Cortez

18. Mother's Name *(First, Middle, Meiden Surneme)*: Frances Spitzschuh

19a. Informent's Neme/Reletionship *(Type, Print)*: Barry Wayne Graves Spouse

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 13313 Nassau Dr. Dale City, VA 22193

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: AAA Crematory

Dete: 1-25-2001

20c. Location - City or Town, Stete: Woodbridge, VA

21. Signature of Funerel Service Licensee: ▶ Peter L. Pintell

22. Neme end Address of Feciility: 3200 Golansky Blvd. Miller Funeral Home Woodbridge, VA 22192

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death)

a. Sepsis — 2 Weeks

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

b. gastric ulcer with fistula — 2 Weeks

Due to (or es e consequenca of):

c. venous line sepsis — 3-5 days

Due to (or as e consequenca of):

d. gastric resection with bypass — 3 Weeks

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

gastric ulcer with multiple episodes of bleeding

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ William F Marcus MD

29c. License number: D07040

29d. Date signed *(Month, Day, Year)*: 1/23/2001

30. Neme end eddreaa of parson who completed cause of deeth (Item 23e) (Type, Print): William Marcus 10801 Lockwood Dr. #325 Silver Spring, Md. 20901

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 30 2001

32. Registrar's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALAN RAY HATTON
2. Date of Death (Month, Day, Year): JANUARY 13, 2001
3. Time of Death: 4:45 AM
4a. Facility Name (If not institution, give street and number): 9089 Athol Road
4b. City, Town, or Location of Death: Mardela Springs
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 217-42-5327
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 23, 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Mardela Springs
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9089 Athol Road
10f. Zip Code: 21837
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Compliance Specialist
16b. Kind of Business/Industry: Dept. of Environment State of Maryland

17. Father's Name (First, Middle, Last): H. Dail Hatton
18. Mother's Name (First, Middle, Maiden Surname): Doris V. Knowles

19a. Informant's Name/Relationship (Type, Print): Faye B. Hatton/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9089 Athol Rd., Mardela Springs, MD 21837

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mardela Memorial Cemetery
Date: 1/16/01
20c. Location - City or Town, State: Mardela Springs, MD

21. Signature of Funeral Service Licensee: Keith R. Mearney CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Sarcoma — 2yrs

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due fo (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D26278
29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID COWELL, MD 145 E. Carroll St. Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

8 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUGENE RAYMOND HOHMAN
2. Date of Death: Month JAN. Day 11 Year 2001
3. Time of Death: 0745
4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 217-14-3771
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/16/1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: SELBYVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 14 SAND DOLLAR LANE, KEENWICK WEST
10f. Zip Code: 19975
10g. Citizen of What Country: USA

11. Maritel Status: 1 [ ] Never Merried 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Yaer or Detas: 1945-46
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): CLARENCE J. HOHMAN
18. Mother's Neme (First, Middle, Maiden Sumame): BERTHA M. HAVERKAMP

19a. Informent's Neme/Reletionship (Type, Print): DIANE H. SCHOEN/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 WEST STONEY RUN, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): CREMATORY OF DELMARVA
Date: 1/13/01
20c. Location - City or Town, Steta: DELMAR, DELAWARE

21. Signature of Funeral Service Licensee: Ruby W Hastings
22. Nama end Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — FEW YEARS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted avents resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Piece of Injury - At homa, farm, stract, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, end due to the ceuse(s) end menner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar steted.
29b. Signatura and titla of certifier: Dorothy C. Holzworth, M.D.
29c. License number: D06241
29d. Data signed (Month, Dey, Year): 01-11-01

30. Nema end address of person who completes cause of death (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Deanna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Hohman, Eugene 06/16/23 - 1/11/01
217-14-3771

10 mp
1 VA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MABEL LOUISE HARRIS
2. Date of Death (Month, Day, Year): JANUARY 16, 2001
3. Time of Death: 2:45 PM
4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 217-34-2394
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 24, 1918
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6834 JAQUAR COURT
10f. Zip Code: 20603
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ARTHUR ROSS, SR.
18. Mother's Neme (First, Middle, Maiden Surname): MATTIE M. MURRAY

19a. Informant's Neme/Relationship (Type, Print): MARSHA BETTINIA HAWKINS/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6834 JAQUAR COURT, WALDORF, MARYLAND 20603

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Huntt Crematory
Date: 1-20-01
20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: Jack A. Wilson
JACK A. WILSON MO1246
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. Respiratory Failure
Due to (or as a consequence of):
b. Multi-Organ Dysfunction Syndrome
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c. Acute Tubular Necrosis
Due to (or as a consequence of):
d. ? CHF

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
NIDDM, Hypoglycemia, HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted.
29b. Signature and title of certifier
29c. License number: D0053219
29d. Date signed (Month, Day, Year): 1·17·2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zafar A. Ansari, MD, 7E Post Office Road, Waldorf, MD 20602

State Registrar

31. Dete filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JPK

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Julius	HUDSON	Hausmann	January 13 2001	950pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bay View Hospital	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
082-01-7726	1 [X] M 2 [ ] F	91 Yrs.			Sept 16, 1909	New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Woodstock	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1700 New Hampton Lane	21163	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Controller	Finance

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Julius Hausmann	Elizabeth Osthelder

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Margaret Mary Hausmann (Wife)	1700 New Hampton Lane Woodstock, MD 21163

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	All County Cremation Srv	1/15/01	Sykesville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Brian L. Haight	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach lina.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Intracranial Hemorrhage	36hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediata ceuse. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1 [ ] Yas 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Placa of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, data and place, and due to tha cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and menner stated.

29b. Signature and title of certifiar	29c. License number	29d. Date signed (Month, Day, Year)
MD	RES-001	January 13 2001

30. Name and address of person who completad ceusa of daath (Item 23a) (Type, Print) 4940 EASTERN AVE.
Jacob Schwarz, MD Bayview Hospital, Baltimore, MD 21224

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signeture
JAN 17 2001	Jennie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02321

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edgar T. Hutton
2. Date of Death Month / Day / Year: January 12, 2001
3. Time of Death: 12:05 A.M.
4a. Facility Name *(If not institution, give street and number)*: Millennium at South River
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 227-20-2487
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 19, 1926
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 380 Colony Point Place
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Minister
16b. Kind of Business/Industry: Religion

17. Father's Name *(First, Middle, Last)*: Scott Hutton
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Rowe

19a. Informant's Name/Relationship *(Type, Print)*: Sheila J. Hutton/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 380 Colony Point Place Edgewater, MD 21037

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: 1-13-01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert Miller
22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration pneumonia — 1 month
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Normal pressure hydrocephalous; Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1 [ ] Yes 2 [ ] No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Donna Chambers MD
29c. License number: D48101
29d. Date signed *(Month, Day, Year)*: 1/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONNA CHAMBERS MD 1833A Forest Dr. Annapolis MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIOLET A. JOHNSON
2. Date of Death (Month, Day, Year): JAN. 14 2001
3. Time of Death: 1335
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-20-8504
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 6, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4842 Campground Road
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Shirt Manufacturing

17. Father's Name (First, Middle, Last): George S. Bozman
18. Mother's Name (First, Middle, Maiden Surname): Edna Harris

19a. Informant's Name/Relationship (Type, Print): Robert A. Johnson/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4842 Campground Rd., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Siloam Cemetery
Date: 1/17/01
20c. Location - City or Town, State: Siloam, MD

21. Signature of Funeral Service Licensee: ▶ [signature] Holloway
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	chronic obstructive pulm disease. Exam.	10 Days.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Respiratory failure	10 Days.
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D32014
29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA 106 MITFORD ST 504B SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Violet Johnson 218-20-8504

6 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02323

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT B. JONES

2. Date of Death (Month, Day, Year): JANUARY 13, 2001

3. Time of Death: 2000

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 238-18-8025

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT. 19, 1919

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: QUEEN ANNES

10c. City, Town or Location: CENTREVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 722 CHURCHILL RD

10f. Zip Code: 21617

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CRANE OPERATOR

16b. Kind of Business/Industry: POLLEN INDUSTRIES

17. Father's Name *(First, Middle, Last)*: ROBERT DOLGER

18. Mother's Name *(First, Middle, Maiden Surname)*: CALLIE PARKER

19a. Informant's Name/Relationship *(Type, Print)*: ROBERT B. JONES - SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 722 CHURCHILL RD CENTREVILLE, MD 21617

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SPRINGHILL MEMORY GARDENS

Date: 1/20/01

20c. Location - City or Town, State: HEBRON, MARYLAND

21. Signature of Funeral Service Licensee: Melissa Kay Hess

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Methicillin Resistant Staph Aureus 2 1/2 weeks

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

End Stage Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D39813

29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL ATKINS, MD 1104 HEALTHWAY DRIVE SALISBURY, MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Denise A. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02324

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NAOMI JOHNSON

2. Date of Death Month: January Day: 3 Year: 2001

3. Time of Death: 315 pm

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NONE

Funeral Director

5. Social Security Number: 218-30-7259

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months: Days: If Under 24 Hrs.: Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: JAN. 29 1932

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6562 HALL AVENUE

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE

16b. Kind of Business/Industry: CROWNSVILLE HOSPITAL

17. Father's Name *(First, Middle, Last)*: JOHN McKINLEY WATKINS

18. Mother's Name *(First, Middle, Meiden Surneme)*: ELIZABETH HICKS

19a. Informant's Name/Relationship *(Type, Print)*: RUTH DARNELL (DAUGHTER)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 6562 HALL AVE. GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: CHEWS CHURCH CEMETERY

Date: 1/8/01

20c. Location - City or Town, State: OWENSVILLE, MD.

21. Signature of Funeral Service Licensee: Larry S. Reese 1100483

22. Name and Address of Fecility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onsel and Death

Immediate Cause (Final diseese or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or Investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] M.D.

29c. License number: P 14569

29d. Date signed *(Month, Dey, Year)*: 1/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda George, M.D. % Maryland General Hospital Baltimore Md.

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 09 2001

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Naomi Johnson

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Michael Judge
2. Date of Death — Month: Jan Day: 1 Year: 2001
3. Time of Death: 12:30 pm
4a. Facility Name (If not institution, give street and number): 746 Annapolis Neck Rd.
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 093-32-7238
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 14, 1941
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 746 Annapolis Neck Road
10f. Zip Code: 21403
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1963-1969
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Environmental Resources Planner
16b. Kind of Business/Industry: County Government

17. Father's Name (First, Middle, Last): Leo M. Judge
18. Mother's Name (First, Middle, Maiden Surname): Anna Opitz

19a. Informant's Name/Relationship (Type, Print): Elizabeth E. Judge/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 610 W. 30th St. #201 Austin, TX 78705

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1/5/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Todd Tilles
22. Name and Address of Facility: John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. coronary artery disease — Due to (or as a consequence of): — years
b. multiple sclerosis — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Briggs MD
29c. License number: D28640
29d. Date signed (Month, Day, Year): Jan 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2414 Hightee Ct. Crofton Md 21114 Jeffrey Briggs MD

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

JAN 0 9 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02326

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Mary Matilda Jones
2. Date of Death Month: January Day: 11 Year: 2001
3. Time of Death: 7:05 pm
4a. Facility Name *(If not institution, give street and number)*: Mallard Bay Care Center
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 218-24-4171
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 09, 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Taylors Island
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: P.O. Box 61 4522 Bay Shore Road
10f. Zip Code: 21669
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Production Line Worker
16b. Kind of Business/Industry: Seafood Industry

17. Father's Name *(First, Middle, Last)*: William Hughes
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Estella Stanley

19a. Informant's Name/Relationship *(Type, Print)*: Lorraine Jones Palmer
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1734 Taylors Island Road Woolford Maryland 21677

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lane U.M. Church Cemetery | Date: 1/18/2001
20c. Location - City or Town, State: Taylors Island, MD.

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, MD. 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Hepatobiliary Carcinoma. — 2 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D
29c. License number: D56659
29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Muhammad Afzal, M.D., 300 Aurora Street, Cambridge, Maryland, 21613

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES SAMUEL KREEGER, JR.

2. Date of Death: Month JAN Day 08 Year 2001

3. Time of Death: 1201AM

4a. Facility Name (If not institution, give street and number): CHESAPEAKE WOODS NURSING HOME

4b. City, Town, or Location of Death: CAMBRIDGE

4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 213-01-8376

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 21, 1914

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: DORCHESTER

10c. City, Town or Location: CAMBRIDGE

10d. Insida City Limits: X Yas 2 No

10e. Street and Number: 310 BAYLY AVE

10f. Zip Code: 21613

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STORE MANAGER

16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): JAMES SAMUEL KREEGER, SR

18. Mother's Name (First, Middle, Meiden Sumame): FANNIE CLARISSA ANTHONY

19a. Informant's Name/Ralationship (Type, Print): ANDREA K. WATERS/ GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 BAYLY AVE., CAMBRIDGE, MD 21613

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): CHESAPEAKE CREMATION CTR | Data: 1-10-01

20c. Location - City or Town, Stete: STEVENSVILLE, MD

21. Signature of Funaral Service Licensee: Mona E Mun&V CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition rasulting in death): a. Ischemic Gangrene (R) Lower Limb — 14 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Advanced Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only ona): Hospital: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determinad

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and placa, and due to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: Michael Fallon MD

29c. Licansa number: D26388

29d. Date signed (Month, Dey, Year): JAN 08 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Michael Fallon MD 302 Collins, Hurlock MD 21643

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SBB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Robert Kelly
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 4:10PM
4a. Facility Name (If not institution, give street and number): 4819 Bartholow Road
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 212-50-0504
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 23, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4819 Bartholow Road
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer
16b. Kind of Business/Industry: Engineering

17. Father's Name (First, Middle, Last): Francis N. Kelly
18. Mother's Name (First, Middle, Maiden Surname): Catherine Cross

19a. Informent's Name/Relationship (Type, Print): Mrs. Jacquelyn A. Kelly (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4819 Bartholow Road Sykesville, MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park
Date: 1/11/01
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: ▶ Brian D. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Colo-rectal cancer dx — 22 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Liver, bones + spinal cord

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nicholas Koutroulakos
29c. License number: D38509
29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Koutroulakos 11065 Little Patuxent Pky Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02329

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY STONESIFER KOONS

2. Date of Death Month Day Year: January 12, 2001

3. Time of Death: 2020

4a. Facility Name *(If not institution, give street and number)*: Westminster Nursing & Convalescent Center

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 213-24-8240

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 13 1910

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll County

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2229 Feeser Road

10f. Zip Code: 21787

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usuet Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: sewing machine operator

16b. Kind of Business/Industry: garment manufacture

17. Father's Name *(First, Middle, Last)*: William C. Stonesifer

18. Mother's Name *(First, Middle, Maiden Surname)*: Mettie Shriner

19a. Informent's Name/Relationship *(Type, Print)*: Marvin E. Koons / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2229 Feeser Road Taneytown, Maryland 21787

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, cremetory or other place)*: Baust Church Cemetery

Date: Jan 16 2001

20c. Location - City or Town, State: Westminster, Maryland

21. Signature of Funeral Service Licensee: Alan C. Dunn M01072

22. Name and Address of Fecility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)
a. ASCVD — 20yr

Due to (or as e consequenca of):
b. AMI — 1hr

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c. Cardiomyopathy — 3y

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicat exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigatton, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: John Middleton

29c. License number: D25443

29d. Date signed *(Month, Dey, Year)*: 1-13-2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): John W. Middleton 684 Pooks Rd Westminster Md 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Denise A Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02330

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph U. Kinzer
2. Date of Death: Month JAN Day 12 Year 2001
3. Time of Death: 7 20 PM
4a. Facility Name (If not institution, give street and number): Westminster Nursing and Convalescent Ctr.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-07-1339
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Mar 31 1916
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 215 Garden Way
10f. Zip Code: 21157
10g. Citizen of What Country: USA

11. Meritel Statua: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates: 1935 1937
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Bethlehem Steel Co.

17. Father's Neme (First, Middle, Last): Albert L. Kinzer
18. Mother's Name (First, Middle, Maiden Surname): Mary Emma Lloyd

19a. Informent's Neme/Reletionship (Type, Print): Ruth Kinzer/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 215 Garden Way Westminster, MD 21157

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Westminster Cemetery
Date: 1/16/2001
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Neme and Address of Feclity: Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximele Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. Chronic Osteomyelitis foot — 3 months
Due to (or as a consequence of): Cerebrovascular Accident
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causs of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medicel examiner? 1☐Yes 2☒No
28. Piece of Deeth (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end manner es stated. 2☐Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and place, snd due to the ceuse(s) and menner stated.

29b. Signature end title of certifier: ▶ [signature] INTERNIST, MD
29c. License number: D 52035
29d. Date signed (Month, Day, Year): Jan 13, 2001

30. Nems and address of person who completed ceuse of death (Item 23a) (Type, Print): BINU CHACKO 291 Stoner Avenue Dixon Building WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Joseph Kinzer

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHYLLIS JEAN KING

2. Date of Death (Month, Day, Year): JANUARY 13, 2001

3. Time of Death: 1:41PM

4a. Facility Name (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 235 60 8057

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): OCT. 28, 1937

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: EDGEWATER

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1024 OLD TURKEY POINT ROAD

10f. Zip Code: 21037

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MEAT WRAPPER

16b. Kind of Business/Industry: GROCERY

17. Father's Name (First, Middle, Last): ANDREW A. NORRIS

18. Mother's Name (First, Middle, Maiden Surname): EULA E. LILLY

19a. Informant's Name/Reletionship (Type, Print): JOHN P. KING (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1024 OLD TURKEY POINT ROAD EDGEWATER, MD. 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): HILLCREST CEMETERY

Date: 01-17-01

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral Bleed — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D38445

29d. Date signed (Month, Day, Year): Jan 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Les Weinstein 600 Ridgely Ave, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02332

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Frances Larkin

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 8:45am

4a. Facility Name *(If not institution, give street and number)*: WILLIAM HILL MANOR

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 182-40-4414

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 30, 1914

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 501 DUTCHMANS LANE

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:* X

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JOHN CARNEY

18. Mother's Name *(First, Middle, Maiden Surname)*: EUGENIA LOVE

19a. Informant's Name/Relationship *(Type, Print)*: ROBERT J. LARKIN/ SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 828 WEST LOCUST ST., SEAFORD, DE 19973

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: CHESAPEAKE CREMATION CTR

Date: 1-11-01

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: [signature] CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. general deconditioning, malnutrition — weeks

Due to (or as a consequence of):

b. Rheumatoid arthritis — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D25750

29d. Date signed *(Month, Day, Year)*: 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Ethel Leishear

2. Date of Death: Month Jan Day 13 Year 2001

3. Time of Death: 11:20 AM

4a. Facility Name (If not institution, give street and number): 30 Rose Court

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-07-3690

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 13 1919

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 30 Rose Court

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): August Leishear

18. Mother's Neme (First, Middle, Meiden Surneme): Ethel Uhler

19a. Informant's Name/Relationship (Type, Print): Priscilla Baumgardner Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 30 Rose Ct. Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Lorriane Park Cemetery

Date: Jan. 16, 2001

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: James B Covey

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer — 7 months

Due to (or as a consequence of):

b. Liver metastases — 7 months

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: M.D.

29c. License number: D21649

29d. Date signed (Month, Dey, Year): JAN 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANANDAM BASKARAN 3455 Wilkens Ave Baltimore MD 21229

State Registrar

31. Date filed (Month, Dey, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02334

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET T. MARVEL
2. Date of Death Month Day Year: JANUARY 7, 2001
3. Time of Death: 5:30 PM
4a. Facility Name *(If not institution, give street and number)*: ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCHESTER

Funeral Director

5. Social Security Number: 212-26-7160
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN 30, 1929
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21 PARK LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BROKER
16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name *(First, Middle, Last)*: ERNEST C. TODD
18. Mother's Name *(First, Middle, Maiden Surname)*: EMILY DOUGHERTY

19a. Informant's Name/Relationship *(Type, Print)*: WENDY M. ELLIOTT/ DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29174 PIN OAK WAY, EASTON, MD 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SPRING HILL CEMETERY
Date: 1-10-01
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: Mann & Mann CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. INTRA ABDOMINAL SEPSIS (7 days) 1 week

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. MALNUTRITION

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D46257
29d. Date signed *(Month, Day, Year)*: 1/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9714 Healthway Drive Berlin, MD Berlin, MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Marvel, Margaret T. 2/22/67162 1/30/29 - 1/7/01

SBB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02335

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALBERT JAMES MARVEL
2. Date of Death — Month: Jan; Day: 10; Year: 2001
3. Time of Death: 0205
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 214-32-7211
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 89 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: OCT. 20, 1911
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 29359 DUTCHMANS LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SOLE PROPRIETOR
16b. Kind of Business/Industry: HEATING/AIR CONDITION

17. Father's Name *(First, Middle, Last)*: A. RAYMOND MARVEL
18. Mother's Name *(First, Middle, Maiden Surname)*: LULA MAY JAMES

19a. Informant's Name/Relationship *(Type, Print)*: HELEN V. MARVEL /WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: PO BOX 696 EASTON, MD 21601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SPRING HILL CEMETERY
Date: 1-12-01
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: [signature] LFD
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DM DeShields
29c. License number: D0053110
29d. Date signed *(Month, Day, Year)*: 1/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DENNIS DESHIELDS 219 S. WASHINGTON ST EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001
32. Registrar's Signature: [signature] D. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Albert Marvel
Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02336

MARSHALL MURRAY-DAVIS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH MARSHALL MURRAY-DAVIS
2. Date of Death: Month 01 Day 10 Year 01
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): 104 North Cranberry Road
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-46-8314
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 9, 1907
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 104 North Cranberry Raod
10f. Zip Code: 21157
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Elementary School
17. Father's Name (First, Middle, Last): Charles W. Hunter, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Exall
19a. Informant's Name/Relationship (Type, Print): James W. Davis, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 N. Cranberry Rd, Westminster, MD 21157
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation
Date: 1/11/01
20c. Location - City or Town, State: Hampstead, Maryland
21. Signature of Funeral Service Licensee: ▶ Robert A. Myers
22. Name and Address of Facility: Myers Funeral Home, 91 Willis Street, Westminster, MD 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 18 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Wm. R. Linthicum, MD
29c. License number: D14317
29d. Date signed (Month, Day, Year): 1/10/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM R. LINTHICUM, MD. ONE KINGS DRIVE, TANEYTOWN, MD 21787

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: ▶ Jeanne G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 20b per F.D. 01/17/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02337

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Luther Merle Meachum

2. Date of Death Month Dey Yeer: Jan. 11, 2001

3. Time of Death: 4:00 PM

4a Facility Nama (If not institution, giva street and number): 7433 Watersville Rd.

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 238-14-3133

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): April 25, 1922

9. Birthplace (Stete or Foreign Country): North Carolina

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Carroll

10c. City, Town or Locetion: Mt.Airy

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7433 Watersville Rd.

10f. Zip Coda: 21771

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Give Year or Detas: 1950-1951

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - Amarican Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elemantary/Secondary (0-12): 6th; Collega (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Truck Driver

16b. Kind of Business/Industry: Owner/ Operator

17. Fathar's Neme (First, Middla, Last): William Alexander Meachum

18. Mothar's Name (First, Middla, Maidan Sumame): unknown

19a. Informent's Neme/Ralationship (Type, Print): Cathy Johnson (daughter)

19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7433 Watersville Rd. Mt. Airy, MD 21771

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cametery, cremetory or other place): All County Cremation

Dete: Jan. 16, 2001 ~~Jan. 16, 20001~~

20c. Location - City or Town, Stete: Sykesville, MD

21. Signeture of Funeral Service Licensee:

22. Nama end Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West 01 Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not entar tha mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. Liet only one cause on eech line.

Approximete Intarvel Between Onset end Death

Immedieta Causa (Finel disease or condition resulting in deeth)

a. Ventricular arrhythmia — minutes

Due to (or as e consequence of):

b. myocardial infarction — minutes

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or as a consequence of):

c. coronary artery disease — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings available prior to compiation of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be datarmined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Strast end Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred et the tima, date end plece, end due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha time, dete end plece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Stephen A Valentine

29c. Licanse number: D22681

29d. Date signed (Month, Dey, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 29e) (Type, Print): Stephen A Valentine 10195 little patuxent pkwy Columbia, MD 21044

State Registrar

31. Deta filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signetura: Geneva B Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

01-264-510
crn
Kieran McElwee
amend item 23a,27 per me G791 1/31/01 yf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02338

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kieran M. McElwee
2. Data of Death Month Day Year: January 16, 2001
3. Time of Death: 6:28 A.M.
4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 164-60-2792
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 21 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 13,1979
9. Birthplaca *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Penna
10b. County: Montgomery
10c. City, Town or Locaiion: Lafayette Hill
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3027 Crescent Avenue
10f. Zip Code: 19444
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Student
16b. Kind of Business/Industry: College

17. Father's Nama *(First, Middle, Last)*: Charles McElwee
18. Mother's Name *(First, Middle, Maiden Surnama)*: Sally McAlcer

19a. Informent's Neme/Reletionship *(Type, Print)*: Charles McElwee, father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3027 Crescent Ave, Lafayette Hill, PA 19444

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☒ Ramoval from State 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: Calvary Cemetery — Dete: 1/20/2001
20c. Location - City or Town, State: West Conshohocken, PA

21. Signature of Funeral Service Licensee: M00723 Steven W Elmi
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on aach line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. CARDIAC ARRHYTHMIA IN ASSOCIATION WITH AMPHETAMINE USE AND BRONCHIAL ASTHMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yaa 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: A Pestaner MD
29c. Licensa number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mengies Elizabeth McNaught

2. Date of Death: Month Jan Day 15, Year 2001

3. Time of Death: 6:30 am

4a. Facility Name (If not institution, give street and number): Sunrise Assisted Living

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 473-14-4842

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth (Month, Day, Year): Aug. 31, 1910

9. Birthplace (State or Foreign Country): MO

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 41 Cypress Creek Road

10f. Zip Code: 21146

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Robert Brown

18. Mother's Name (First, Middle, Maiden Surname): Audrey Campbell

19a. Informant's Name/Relationship (Type, Print): Barbara Novak/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1131 Asquith Drive, Arnold, MD 21012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunland Memorial Park

Date: Jan 18 2001

20c. Location - City or Town, State: Sun City, AZ

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. advanced dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) assisted living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D-50725

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jennifer Riedinger 479 Jumpers Hole Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02340

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry C. Millhausen

2. Date of Death (Month, Day, Year): Jan 10, 2001

3. Time of Death: 9:40 pm

4e Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-24-9343

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 22, 1925

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 659 Arleigh Road

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Clerk

16b. Kind of Business/Industry: Federal

17. Father's Name (First, Middle, Last): Harry Millhausen

18. Mother's Name (First, Middle, Maiden Surname): Margaret Corcoran

19a. Informant's Name/Relationship (Type, Print): Emily Millhausen/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 57, Severna Park, MD 21146

20e. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Jan 12 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park FuneralHome 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ENCEPHALOPATHY — 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOL USE

HYPERTENSION

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably ☒Unknown

24a. Was an autopsy performed? 1☐Yes ☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes ☒No

26. Place of Death (Check only one): Hospital: ☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: ☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): ☒1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DS MITCHELL

29c. License number: D39037

29d. Date signed (Month, Day, Year): 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DS MITCHELL, AAMC, ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPS
01-0189-013
ERICA NORTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Erica Marie Norton
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 18:45
4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213-98-4048
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 20 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14 1980
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2507 Vance Drive
10f. Zip Code: 21771
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Junior College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Towson State University

17. Father's Name (First, Middle, Last): George Thomas Norton, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Josette Tunney

19a. Informant's Name/Relationship (Type, Print): parents Mr. & Mrs. George T. Norton, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2507 Vance Drive Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pine Grove Cemetery
Date: Jan. 15
20c. Location - City or Town, State: 2001 Mt. Airy, MD

21. Signature of Funeral Service Licensee: James B Conway
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Bacterial Meningitis (Neisserial)
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Clarke MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARSON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02342

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ellsworth E. Naill

2. Date of Death (Month, Day, Year): Jan. 14 2001

3. Time of Death: 11:30 PM

4a. Facility Name *(If not institution, give street and number)*: 3210 HoopersDelight Road

4b. City, Town, or Location of Death: New Windsor

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-28-8409

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 5 1927

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: New Windsor

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3210 HoopersDelight Road

10f. Zip Code: 21776

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 1st grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: self-employed

17. Father's Name *(First, Middle, Last)*: Edward Naill

18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Glass

19a. Informant's Name/Relationship *(Type, Print)*: Doris E. Naill Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3210 Hoopers Delight Road New Windsor, MD 21776

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Bethany Cemetery

Date: Jan 19,

20c. Location - City or Town, State: 2001 New Windsor, MD

21. Signature of Funeral Service Licensee: James B Covey

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Sykesville, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death) a. IASCVD — years

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Metastatic Renal Carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the besis of examination and/or investigation, in *my* opinion, death occurred at the time, dete and pleca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Herbert P. Henderson MD

29c. License number: D0051924

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307 Westminster MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02343

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gerald Sanford Norton

2. Date of Death Month Day Year: Jan. 15, 2001

3. Time of Death: 2130

4a. Facility Name *(If not institution, give street and number)*: 398 Ridgely Avenue

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 194-12-0737

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs. If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 17, 1916

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 398 Ridgely Avenue

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1934-1970

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): +6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Capt. USN

16b. Kind of Business/Industry: United States Navy

17. Father's Name *(First, Middle, Last)*: Frank E. Norton

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Drum

19a. Informant's Name/Relationship *(Type, Print)*: Mary Kent Hewitt Norton (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 398 Ridgely Ave. Annapolis, Maryland 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 01/17/2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Beverly M. Sailor

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ca Prostate — 24

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD
HTN
TCU

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21438

29d. Date signed *(Month, Day, Year)*: Jan 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 600 RIDGELY AVE, STE 120 ANNAPOLIS MD 21401-1077 Michael LaPenta

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02344

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD CONRAD OLSON
2. Date of Death Month Day Year: JANUARY 5, 2001
3. Time of Death: 10:30 AM

Funeral Director

4a. Facility Name *(If not institution, give street and number)*: 28573 NINTH DRIVE
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

5. Social Security Number: 213-28-9950
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAR 12, 1923
9. Birthplace *(State or Foreign Country)*: CA

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 28573 NINTH DRIVE
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICAL ENGINEER
16b. Kind of Business/Industry: STEEL

17. Father's Name *(First, Middle, Last)*: CONRAD E. OLSON
18. Mother's Name *(First, Middle, Maiden Surname)*: LUCY PRESTON

19a. Informant's Name/Relationship *(Type, Print)*: MARY LEE OLSON/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28573 NINTH DRIVE EASTON, MD 21601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR
Date: 01-09-01
20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: [signature] CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GLIOBLASTOMA MULTIFORME — 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D26350
29d. Date signed *(Month, Day, Year)*: JANUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM S. BREMER M.D. 800 S. TALBOT ST. ST MICHAELS, MD 21663

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBS.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02345

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BENJAMIN HAYDEN PENTZ SR

2. Date of Death — Month: JANUARY Day: 7 Year: 2001

3. Time of Death: 12:50 PM

4a. Facility Name *(If not institution, give street and number)*: HOSPICE HOUSE

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 213-03-8185

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 2, 1906

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: ST. MICHAELS

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7960 OAKWOOD PARK COURT

10f. Zip Code: 21663

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: EXECUTIVE

16b. Kind of Business/Industry: OFFICE EQUIPMENT

17. Father's Name *(First, Middle, Last)*: CHARLES WILLIAM PENTZ

18. Mother's Name *(First, Middle, Maiden Surname)*: ANGELA JOSEPHINE GROSSI

19a. Informent's Name/Relationship *(Type, Print)*: FRANCES M. PENTZ/ WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: PO BOX 700 ST. MICHAELS, MD 21663

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR — Date: 1-08-01

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: M. E. Newnam III CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 1 year.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia.
Inanition
Decubitus ulcer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [✓] Other *(Specify)* Hospice

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R A Schilling DO

29c. License number: H42587

29d. Date signed *(Month, Day, Year)*: 01-08-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Russell A. Schilling DO. 555 Cynwood Dr Easton md 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SBB

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02346

Claude Pardoe

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
CLAUDE GROVER PARDOE	Jan	8	2001	1632

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-34-9266	1☒ M 2☐ F	97 Yrs.					MAY 10, 1903	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	CORDOVA	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11300 KITTYS CORNER RD	21625	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	FARMER	DAIRY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM SAMUEL PARDOE	LONA LANE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAMUEL LEE PARDOE	11276 KITTYS CORNER RD, CORDOVA, MD 21625

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SPRING HILL CEMETERY	1-12-01	EASTON, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Marc S Newnam FD CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Massive Hematoma and ecchymosis left arm & trunk	
Due to (or as a consequence of):	b. Comminuted left Humeral Head fracture	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Seizure, convulsive, due to cerebral embolism	
Due to (or as a consequence of):	d. Atrial fibrillation, chronic	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory insufficiency due to emphysema

Thrombocytopenia due to pernicious anemia

David Stout, MD. ME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? Cleared by Forensic Technician 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	01-05-01	~11 A M	1☐ Yes 2☒ No	Fall to floor in Bathroom

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Meridian - The Pines Nursing Home	Easton MD Dutchmans Lane & US 50

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert W. Trever, M.D	D 10938	01-08-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT W. TREVER M.D. 7696 OCEAN GATEWAY EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 10 2001	▶ Lisa G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Wesley Pearson
2. Date of Death (Month, Day, Year): Jan. 8, 2001
3. Time of Death: 7:45 am
4a. Facility Name (If not institution, give street and number): 233 Brookwood ave
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 215-38-7761
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 23, 1933
9. Birthplace (State or Foreign Country): Md.

Usual Residance of Dacedant

10a. State: Md.
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 233 Brookwood ave.
10f. Zip Coda: 21601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Marriad 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedant Ever in U.S. Armed Forces? 1 [ ] Yas 2 [ ] No If Yas, Giva Yaer or Datas: 5/55 5758
13. Was Dacedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Raca - Amarican Indian, Black, White, atc. Specify: Black

15. Decedant's Education (Specify only highast grada compliated): Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Not Employed
16b. Kind of Businass/Industry: health reasons

17. Fathar's Nama (First, Middla, Last): Charlie Holmes
18. Mothar's Name (First, Middla, Maidan Sumama): Emily Mae Murray

19a. Informant's Name/Raiationship (Typa, Print): Jessie Brice/ sister
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 233 Brookwood ave. Easton, md. 21601

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramovel from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Nama of cematery, cremetory or other placa): Md. Veterans Ceme.
Data: 1/12/01
20c. Location - City or Town, Stata: Hurlock, Md.

21. Signatura of Funeral Service Licensee: Eric L. Dashiell
22. Nama and Address of Facility: Dashiell Funeral Services 319 E. Dover st. Easton, Md. 21601

Physician /Medical Examiner

23a. Part I. Enter tha diseese, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Intarval Batwaen Onset and Death

Immediete Ceuse (Final disaasa or condition resulting in daath):
a. presumed acute cardiac event — minutes
Dua to (or as a consaquanca of):
b. atherosclerosis — 4 years
Sequentially list conditions, if any, leading to immadieta causa. Entar Underlying Ceusa (Disease or injury that initiated avents resulting in daeth) Last
Dua to (or as a consequanca of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause givan in Part I.: generalized seizure disorder

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to completion of cause of daath? 1 [ ] Yas 2 [ ] No

25. Wes casa rafarred to medical examiner? 1 [ ] Yas 2 [X] No

26. Placa of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [X] Rasidanca 6 [ ] Othar (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): 1 [X] **Certifying Phyaician:** To tha best of my knowledga, death occurred at the time, data and place, and dua to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, dete and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of cartifiar: MD
29c. Licansa number: D25750
29d. Date signed (Month, Day, Year): 1/10/01

30. Nama and address of parson who completed causa of death (Item 23e) (Type, Print): R. B. Sanchez MD 507 Idlewild Ave Easton, MD 21601

State Registrar

31. Data filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signatura: D. Sparks

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 10c Per F.D. 01/16/01, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Anthony Purdum

2. Date of Death: Month Jan, Day 13, Year 2001

3. Time of Death: 1:45am

4a. Facility Name (If not institution, give street and number): 2416 Kays Mill Road

4b. City, Town, or Location of Death: Finksburg

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-48-1463

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28 1949

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: ~~Finksburg~~ Finksburg

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No X

10e. Street and Number: 2416 Kays Mill Road

10f. Zip Code: 21048

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief of MBE Section

16b. Kind of Business/Industry: State Highways Administration

17. Father's Name (First, Middle, Last): Albert Purdum

18. Mother's Name (First, Middle, Maiden Surname): Irma Reithmuller

19a. Informant's Name/Relationship (Type, Print): Linda Purdum/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2416 Kays Mill Road Finksburg, MD 21048

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakeview Mem Park | Date: 1/16/2001

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatocellular Carcinoma — 6 months
Due to (or as a consequence of):
b. Cirrhosis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Hepatitis C (HCV)
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD FACP

29c. License number: D41688

29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank A. Anania, MD, Room N3W50 22 S. Greene Street, Balt. MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02349

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET A. PARKER

2. Date of Death (Month, Day, Year): JAN. 12 2001

3. Time of Death: 0800

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216-24-4881

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 30 1910

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 909 B ROYAL STREET

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC

16b. Kind of Business/Industry: OUT OF THE HOME

17. Father's Name *(First, Middle, Last)*: HARVEY HUTTON

18. Mother's Name *(First, Middle, Maiden Surname)*: CARRIE THOMAS

19a. Informant's Neme/Relationship *(Type, Print)*: RANDOLPH PARKER (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1212 BRASHEARS ST. ANNAPOLIS,MD. 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BREWER HILL CEMETERY

Date: 1/19/01

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: Harry D. Reese M001182

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS,MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — Due to (or as a consequence of): Urinary Tract Infection — 24hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ira Weinstein MD

29c. License number: D38445

29d. Date signed *(Month, Day, Year)*: Jan 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Weinstein 600 Ridgely Ave Annapolis MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Donna P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02350

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Taylor Pierce
2. Date of Death: Month January, Day 7, Year 2001
3. Time of Death: 1:00 AM
4a. Facility Name (If not institution, give street and number): Ginger Cove Health Care Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 575-14-3908
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 24, 1907
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7204 River Crescent Drive
10f. Zip Code: 21401
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): +4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator
16b. Kind of Business/Industry: Elementary Education
17. Father's Name (First, Middle, Last): Louis Taylor
18. Mother's Name (First, Middle, Maiden Surname): Margaret Butcher
19a. Informant's Name/Reletionship (Type, Print): John T. Pierce (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Grouse Court Sommersville, SC 29485
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metroplitan Crematory
Date: 1/9/01
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensee: ▶ C Brian Powell
22. Name and Address of Facility: John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. STROKE — Approximate Interval: 1 wk
Due to (or as a consequence of):

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Robert Julian MD
29c. License number: D30718
29d. Date signed (Month, Day, Year): 01 08 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Jackson MD 2003 Med. Pkwy #400, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: ▶ Donna B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne P. Rose

2. Date of Death: Month Jan. Day 13, Year 2001

3. Time of Death: 0610

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-09-8422

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 19, 1905

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 418 Arundel Beach Road

10f. Zip Code: 21146

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Theodore Payrleitner

18. Mother's Name (First, Middle, Maiden Surname): Mary Oneill

19a. Informant's Name/Relationship (Type, Print): Neill Ketchum/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 1538 Fallbrook, CA 92088

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Jan 16 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas F. Allen

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure

Due to (or as a consequence of):
b. Anterior Myocardial infarction — Approximate Interval Between Onset and Death: 2-3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles W. Phelps MD

29c. License number: D41816

29d. Date signed (Month, Day, Year): 1/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles W. Phelps Anne Arundel Medical Center 64 Franklin St. Annapolis, Md. 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02352

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILDRED HOKE RENSHAW

2. Dete of Death Month Day Yeer: JANUARY 5 2001

3. Time of Death: 6:20 p.m

4a Facility Name *(If not institution, give street and number)*: SPA CREEK CENTER

4b. City, Town, or Location of Deeth: ANNAPOLIS

4c. County of Deeth: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219 12 2339

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 79 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: DEC 2 1921

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 105 VICTOR PARKWAY

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Maritat Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indien, Bteck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Fether's Name *(First, Middle, Last)*: WALTER LEE HOKE

18. Mother's Name *(First, Middle, Meiden Surneme)*: HILDA CRONISE

19a. Informent's Name/Relationship *(Type, Print)*: ELISE FLEEHARTY(daughter)

19b. Melting Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 105 VICTOR PARKWAY ANNAPOLIS MD 21403

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory

Date: 1/8/01

20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Servica Licensee: ▶ Melanie Wilhelm Wagoner

22. Name and Address of Facility: Advent Funeral and Cremation Services Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death) a. Emphysema

Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ [signature]

29c. License number: D32036

29d. Date signed *(Month, Dey, Year)*: 1/7/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary T. Sprouse 2108 D. Dorch Drive Chester MD 21619

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 09 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROGER WAYNE SMITH

2. Date of Death: Month JAN Day 13 Year 2001

3. Time of Death: 1545

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-56-1699

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 18, 1950

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Princess Anne

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13220 New Road

10f. Zip Code: 21853

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fork Life Operator

16b. Kind of Business/Industry: Furniture Manufacturing

17. Father's Name (First, Middle, Last): Edgar Lee Smith

18. Mother's Name (First, Middle, Maiden Surname): Mamie Elizabeth Martin

19a. Informant's Name/Relationship (Type, Print): Margaret Smith/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13220 New Rd., Princess Anne, MD 21853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens

Date: 1/18/01

20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral Service Licensee: David H. Thompson M01051

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Brain Death — Minutes

Due to (or as a consequence of):
b. Intracerebral Hemorrhage, Massive — Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Coagulopathy. — Days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hx Aortic Valve Replacement

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Cinderella MD

29c. License number: D44069

29d. Date signed (Month, Day, Year): 01.13.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Cinderella MD 106 Milford St, # 605 Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Roger W. Smith 212-56-1699

10 DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02354

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Auslee Slaughter, Sr.

2. Date of Death Month / Day / Year: Jan 4 2001

3. Time of Death: 1923

4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-07-0314

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 9,1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Oxford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 26322 Oxford Road

10f. Zip Code: 21654

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: Groundskeeper

16b. Kind of Business/Industry: Ship Yard for Boats

17. Father's Name *(First, Middle, Last)*: Nathan Slaughter

18. Mother's Name *(First, Middle, Maiden Surnama)*: Fannie Murray

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn Slaughter / Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 107 Blake Street, Easton,Maryland 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Name of cemetary, crematory or othar placa)*: Queen Esther Cemetery

Date: 1/10/2001

20c. Location - City or Town, State: Ivytown,Maryland

21. Signature of Funeral Service Licensee ▶

22. Nama and Address of Facility: Bennie Smith Funeral Home, 426 Dover Street, Easton,Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Tachycardia — Immediate

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b. Pulmonary Hemorrhage — 1 hour

Due to (or as a consequanca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referrad to *medical* examiner? 1☐ Yes 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of *my* knowledga, daath occurred at the time, date and placa, and due to tha causa(s) and *manner* as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the tima, date and placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Noel Hunte MD

29c. License number: D0055225

29d. Date signed *(Month, Day, Year)*: 1/5/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Noel Hunte,MD , 219 south Washingtown Street,Easton,Maryland 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 2001

32. Registrar's Signature ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

William Slaughter
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

583

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARA MAY SEIGLER
2. Date of Death: Month JANUARY Day 5 Year 2001
3. Time of Death: 9:20 AM
4a. Facility Name (If not institution, give street and number): 4599 CEDAR PLACE
4b. City, Town, or Location of Death: BETHLEHEM
4c. County of Death: CAROLINE

Funeral Director

5. Social Security Number: 214-36-5777
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 7, 1939
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: CAROLINE
10c. City, Town or Location: BETHLEHEM
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4599 CEDAR PLACE
10f. Zip Code: 21609
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name (First, Middle, Last): CHARLES LEONARD WHITBY, JR.
18. Mother's Name (First, Middle, Maiden Surname): ANNEBEL MEREDITH FOGWELL

19a. Informant's Name/Relationship (Type, Print): CHARLES L. WHITBY, III/ SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 10 BETHLEHEM, MD 21609

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CTR
Date: 01-06-01
20c. Location - City or Town, State: STEVENVILLE, MD

21. Signature of Funeral Service Licensee: [signature] CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cedon Carcinoma — 5months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D31887
29d. Date signed (Month, Day, Year): 1/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David H. Smith, M.D - 29466 Pintail Dr. Suite #5, Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

CLARA SPEIGLER 01-05-01 9:20 AM

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

SBS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02356

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ANNA M. SHAKESPEARE

2. Dete of Death — Month: JANUARY; Dey: 6; Yeer: 2001

3. Time of Death: 3:00 AM

4a Facility Neme *(If not institution, give street and number)*: 26949 MILES RIVER RD

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Sociel Security Number: 169-28-8614

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months: ; Deys:

If Under 24 Hrs.: Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: SEPT. 12, 1935

9. Birthplece *(Stete or Foreign Country)*: PA

Usuel Residence of Decedent

10a. Stete: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 26949 MILES RIVER RD

10f. Zip Code: 21601

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yaar or Detas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: REGISTERED NURSE

16b. Kind of Business/Industry: HEALTH

17. Fether's Neme *(First, Middle, Last)*: CALVIN C. CHRISTMAN

18. Mother's Neme *(First, Middle, Maiden Sumame)*: HANNAH DEANE

19e. Informent's Neme/Relationship *(Type, Print)*: WILLIAM SHAKESPEARE/HUSBAND

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 26949 MILES RIVER RD EASTON, MD 21601

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: ST. JOSEPHS CEMETERY

Dete: 1-09-01

20c. Location - City or Town, Stete: CORDOVA, MD

21. Signeture of Funerel Service Licensee: M. E. Newnam III C.F.S.P.

22. Neme end Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Final diseese or condition resulting in deeth): a. Lung carcinoma — Approximate Interval: 9 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic obstructive pulmonary disease; Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: David G Oliver MD

29c. Licanse number: 039749

29d. Date signed *(Month, Dey, Yeer)*: 1/8/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): David G Oliver MD 503 Dutchmans Lane Easton MD 21601

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 0 8 2001

32. Registrer's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

588

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joan M. Sewell
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 1620
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 097-54-4440
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 26, 1955
9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10e. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7401 New Hampshire Ave.
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Some one else's Home

17. Father's Name (First, Middle, Last): Isaac Sewell
18. Mother's Name (First, Middle, Maiden Surname): Mable Bailey

19a. Informant's Name/Relationship (Type, Print): Oradelle Sewell/ sister-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 68 Clark Street, Harrington, Delaware 19952

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hollywood Cemeterey
Date: 1/13/2001
20c. Location - City or Town, State: Harrington, Delaware

21. Signature of Funeral Service Licensee: John A. Prince
22. Name and Address of Facility: Bennie Smith Funeral Home, 426 Dover Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. METASTATIC BREAST CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D42749
29d. Date signed (Month, Day, Year): 01-09-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Raymond Nwadiuko, 9831 Greenbelt Road, Lanham, Maryland 20706

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02358

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Eugene Shelton

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 11:30 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 218-38-2241

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 7, 1941

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Libertytown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12113 Main St.

10f. Zip Code: 21762

10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1960-62

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): carpenter

16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): Emory Eugene Shelton

18. Mother's Name (First, Middle, Maiden Surname): Ruth Marie Bruchey

19a. Informent's Name/Relationship (Type, Print): Linda C. Shelton/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12113 Main St., P.O. Box 445, Libertytown, MD21762

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem. Gardens

Date: 1/13/01

20c. Location - City or Town, State: Frederick, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final diseese or condition resulting in death) a.	VENTRICULAR FIBRILLATION	70 min
Due to (or as a consequence of): b.	ACUTE MYOCARDIAL INFARCTION	70 min
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	UNKNOWN
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner stated.

29b. Signature end title of certifier: Geo. I. Smith, M.D. VPMA

29c. License number: D10587

29d. Date signed (Month, Day, Year): 1/11/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH M.D. VICE-PRES MED AFFAIR, FREDERICK MEMORIAL HOSP. FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grover Vernon Staub

2. Date of Death: Month January Day 12 Year 2001

3. Time of Death: 12:00 PM

4a. Facility Name (If not institution, give street and number): Long View Nursing Home

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-01-2036

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 7, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2115 Ridge Rd.

10f. Zip Code: 21157

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): bus driver

16b. Kind of Business/Industry: charter bus service

17. Father's Name (First, Middle, Last): Grover Cleveland Staub

18. Mother's Name (First, Middle, Maiden Surname): Grace Frantz

19a. Informant's Name/Relationship (Type, Print): S. Jane Staub - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2115 Ridge Rd., Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadow Branch Cemetery

Date: Jan. 15 2001

20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service License: Katharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home 310 Church St., New Windsor, MD 21776

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Advanced Dementia

Due to (or as a consequence of):
b. Non Insulin dependent Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D 51705

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. PANSURIYA, MD 419F, Malcolm DR, Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Deanna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02360

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Burchard Stewart III

2. Date of Death Month Day Year: Jan 15 2001

3. Time of Death: 6:00 PM

4a. Facility Name *(If not institution, give street and number)*: Chapel Hill Nursing Center 4511 Robosson Rd

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-09-9586

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 26, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: Springfield Hospital Center

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: David Burchard Stewart, II

18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Merrick Stewart (Brother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 819 Jonker Court Gaithersburg, MD 20878

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: All County Cremation Srv

Date: 1/17/01

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Brian A. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. (B) Fall - Dementia ulcer.

Due to (or as a consequence of):

c. Pressure Ulcer

Due to (or as a consequence of):

d. Recurrent - Pneumonia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Benign Prostatic Hypertrophy

Schizophrenia chronic.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Sinniger MD

29c. License number: D30119

29d. Data signed *(Month, Day, Year)*: 1-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAHIDA SIDDIQI 6212 SYKESVILLE ROAD SYKESVILLE, MD 21784

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02361

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Bradley Stevens Sr.

2. Date of Death Month / Day / Year: JANUARY 12 2001

3. Time of Death: 2:52AM

4a Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-28-2088

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 27 1933

9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3707 Nauset Place

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 8

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: teacher

16b. Kind of Business/Industry: education

17. Father's Name *(First, Middle, Last)*: Paul B. Stevens

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Stevens

19a. Informent's Name/Relationship *(Type, Print)*: Jeanne Stevens (spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3707 Nauset Place, Randallstown, Md 21133

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Parkwood Cemetery | Date: 1-16-01

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: ▶ Brian K. Haight

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. ACUTE PROMYELOCYTIC LEUKEMIA — ONE WEEK

Due to (or as a consequenca ot):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence ot):

c.

Due to (or as a consequenca of):

d.

Part II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy tindings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yas 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David G. Kaplan MD

29c. Licanse number: D0055583

29d. Date signed *(Month, Dey, Year)*: January 12, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DAVID G. KAPLAN, MD 6701 N. CHARLES ST ROOM 3853 BALTIMORE MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Stevens, Paul

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02362

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Waring Stinchcomb
2. Date of Death: Month January Day 10, Year 2001
3. Time of Death: 8:00 PM
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-22-4266
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 29, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2613 Brooks Drive
10f. Zip Code: 20746
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Photographer
16b. Kind of Business/Industry: Photography

17. Father's Name *(First, Middle, Last)*: Elder Tydings Stinchcomb
18. Mother's Name *(First, Middle, Maiden Surname)*: Etta Waring

19a. Informant's Name/Relationship *(Type, Print)*: Marjorie Stinchcomb/sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4410 Aspen Hill Road Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Asbury U.M. Church Cemetery
Date: 1/15/01
20c. Location - City or Town, State: Arnold, MD

21. Signature of Funeral Service Licensee: Todd E. Miller
22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOMA — > 1 MTH

Due to (or as a consequence of):
b. CARCINOMA OF COLON — > 2 MTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: RB Sawdy MD
29c. License number: D27744
29d. Date signed *(Month, Day, Year)*: 01/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ. SAMTANI MD 9131 PISCATAWAY RD. CLINTON MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02363

1008 1/12/01 Tingle, Robert B. SS# 222 18 0968 DOB 10/31/31

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
ROBERT	B.	TINGLE	JANUARY	12	2001	10:08 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ATLANTIC GENERAL HOSPITAL	BERLIN	WORCESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-18-0968	1☒ M 2☐ F	69 Yrs.					OCT. 31, 1931	DELAWARE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WORCESTER	BISHOPVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11419 BACK CREEK ROAD	21813	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		GUARD SERGEANT	MANUFACTURING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
OLIVER F. TINGLE	MARY BAKER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOYCE ANN TINGLE/WIFE	11419 BACK CREEK ROAD, BISHOPVILLE, MD 21813

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ZION CEMETERY	1/15/01	BISHOPVILLE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Charles W Hastings	HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. myocardial infarction	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. coronary artery disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ No 3☒ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	C1D003949 DE	January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALLY DOWLING MD P.O. BOX 329, SELBYVILLE, DELAWARE 19975

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

TMP IVR

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02364

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilbur Denton Trott

2. Date of Death Month / Day / Year: JANUARY, 16, 2001

3. Time of Death: 12:15 AM

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-03-1997

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 22, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Eldersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6204 N. Walnut Avenue

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tool Finisher

16b. Kind of Business/Industry: Tool Maker

17. Father's Name *(First, Middle, Last)*: Roy Sylvester Trott

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Ientha Trott

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Edna F. Trott (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6204 N. Walnut Avenue Eldersburg, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Oakland Cemetery

Date: 1/19/01

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Brian L. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRO-VASCULAR-ACCIDENT (AGRGE INTRACEREBRAL BLEED)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

H/O CEREBROVASCULAR ACCIDENT

H/O SEIZURE DISORDER

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D51245

29d. Date signed *(Month, Day, Year)*: JANUARY, 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF CARROLL COUNTY GENERAL HOSPITAL - 200 Memorial Ave. WESTMINSTER MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02365

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert Carlton Trail

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 12:10AM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-01-9438

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 17, 1919

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: Carroll Lutheran Health Care Center

10f. Zip Code: 21158

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Herbert Hodges Trail

18. Mother's Name (First, Middle, Maiden Surname): Bertie Trail

19a. Informant's Name/Relationship (Type, Print): Mrs. Virginia Sellers (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3009 Traceys Mill Road Manchester, MD 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Memorial Park

Date: 1/13/01

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: ▶ Brian R. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ① L-Pneumonia — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Advanced Chronic Obstructive Pulmonary Dz. — few yrs.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D37949

29d. Date signed (Month, Day, Year): Jan. 10th 2001

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Alexander Bredenkamp MD 2205 Sener Ave. Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ D Sparks

To be completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be executed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sybil S. Tucker
2. Data of Death: Month Jan. Day 14, Year 2001
3. Time of Death: 1230
4a. Facility Name (If not institution, give street and number): Ginger Cove Health Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 542-12-0023
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 9, 1918
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4000 River Crescent Road
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): James Morris Scroggie
18. Mother's Name (First, Middle, Maiden Surname): Serine Kulseth

19a. Informant's Name/Relationship (Type, Print): James Tucker/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 66 Charles Street, Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Memorial Park
Date: Jan 17 2001
20c. Location - City or Town, State: Easton, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CVA — 60h

Due to (or as a consequence of):
b. HTN — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ca Breast
Dementia, Severe

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D21438
29d. Date signed (Month, Day, Year): Jan 15 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. LAPENTA MD 600 RIDGELY AVE STE 210 21401-1077

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-l show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julius Tuller

2. Date of Death: Month January Day 11 Year 2001

3. Time of Death: 8:15 A.M.

4a. Facility Name (If not institution, give street and number): Genesis Eldercare Center-Spa Creek

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 052-09-3691

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 17, 1913

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 302 Hilltop Lane Apt. D

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [XX] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [XX] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) | College (1-4or 5+): 2 yrs.

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

16b. Kind of Business/Industry: Building Contractor

17. Father's Name (First, Middle, Last): Isadore Tuller

18. Mother's Name (First, Middle, Meiden Surname): Rose Cohen

19a. Informent's Neme/Reletionship (Type, Print): Ray Tuller/ Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 Hilltop Lane Apt. D Annapolis, MD 21403

20a. Method of Disposition: 1 [ ] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metropolitan Crematory

Dete: 1-12-01

20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Pert 1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth)

a. Metastatic Bladder Carcinoma — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauus of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, snd due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 38958

29d. Date signed (Month, Dey, Yeer): 1/11/2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Daljeet Singh Sidhu 1413 Annapolis Road #106 odenton MD 21113

State Registrar

31. Dete filed (Month, Day, Yeer): JAN 16 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02368

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALLEN V. TURNER
2. Date of Death Month Day Year: JAN. 6 2001
3. Time of Death: 12:50 am
4a. Facility Name *(If not institution, giva street and number)*: MILLENNIUN @ MARLEY NECK
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-22-4597
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 25 1928
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GALESVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 880 W. BENNING ROAD
10f. Zip Code: 20765
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER
16b. Kind of Business/Industry: ANNAPOLIS CONCRETE

17. Father's Name *(First, Middle, Last)*: ALLEN V. TURNER
18. Mother's Name *(First, Middle, Maiden Sumema)*: LOUISE NEAL

19a. Informent's Name/Relationship *(Type, Print)*: ERNESTINE BIBB (SISTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 880 W. BENNING RD. GALESVILLE, MD. 20765

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, cremetory or other place)*: EBRNEZER CEMETERY — Date: 1/11/01
20c. Location - City or Town, State: GALESVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Larry D. Reese M00483
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE 1YEAR
Due to (or as a consequence of):
b. ESSENTIAL HYPERTENSION 30YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.
OLD CEREBROVASCULAR ACCIDENT
SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not ba determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Straet and Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Harjit Singh M.D.
29c. License number: D141160
29d. Date signed *(Month, Day, Year)*: JANUARY 06, 2001
30. Name and address of person who completed cause of death (Item 29e) (Type, Print): HARJIT SINGH M.D. 5410-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND - 21225

State Registrar

31. Date filed *(Month, Day, Yeer)*: JAN 09 2001
32. Registrar's Signature: ▶ Geneva B Scott

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02369

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Edward Thommen
2. Date of Death Month Day Year: January 6, 2001
3. Time of Death: 13:05
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-01-0626
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 20, 1907
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 188 West Lake Drive
10f. Zip Code: 21403
10g. Citizen of What Country?: USA

11. Maritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Army
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales
16b. Kind of Business/Industry: Dental

17. Father's Name *(First, Middle, Last)*: William F. Thommen
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Riley

19a. Informent's Name/Relationship *(Type, Print)*: Dee Van Nest (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 188 West Lake Drive, Annapolis, MD 21403

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakemont Cemetery
Date: 1/11/01
20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: Todd Miller
22. Name and Address of Facility: 147 Duke of Gloucester Street John M. Taylor F.H., Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure — 2 weeks
Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hyper natremia
Chronic obstructive pulmonary disorder
Anemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings eveilable prior to completion of cause ot death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to *medical examiner*? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of tnjury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of *my* knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in *my* opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donna Chambers
29c. License number: D48101
29d. Date signed *(Month, Day, Year)*: 1/6/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Donna Chambers MD 1833A Forest Dr Anapolis MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 09 2001
32. Registrer's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

JAN 09 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Crusberg Terhune
2. Date of Death: Month Jan. Day 6, Year 2001
3. Time of Death: 0030
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 042-05-0660
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 27, 1909
9. Birthplace (State or Foreign Country): CT

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 208 St. Ives Garth
10f. Zip Code: 21146
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Gustave Crusberg
18. Mother's Name (First, Middle, Maiden Surname): Anna Maria Bolinder

19a. Informant's Name/Relationship (Type, Print): Robert Frazier/Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 St. Ives Garth, Severna Park, MD 21146

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory — Date: Jan 8, 2000
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James E Barranco
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BRAINSTEM CEREBROVASCULAR ACCIDENT — 2DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ISCHEMIC CARDIOMYOPATHY
HYPERTENSION
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD MPH
29c. License number: P38328
29d. Date signed (Month, Day, Year): 01-06-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY R. CLANCE ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

JAN 0 9 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY KATHRYN WILLIAMS

2. Date of Death (Month, Day, Year): January 14 2001

3. Time of Death: 1115

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 216-14-2046

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 29, 1921

9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: FRUITLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 111 HAYWARD AVE.

10f. Zip Code: 21826

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): THOMAS BAYARD HITCHENS

18. Mother's Name (First, Middle, Maiden Surname): LEVENIA GARRIS

19a. Informant's Name/Relationship (Type, Print): RICHARD A. WILLIAMS - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 HAYWARD AVE. FRUITLAND, MD 21826

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SHAD POINT CEMETERY

Date: 1/18/01

20c. Location - City or Town, State: SHAD POINT, MARYLAND

21. Signature of Funeral Service Licensee: B. Reed Phillips, CFSP

22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

b. Polymyositis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D55658

29d. Data signed (Month, Day, Year): 1/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mary K. Williams

8 DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02372

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Andrew Wallace, Jr.

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 1:15 pm.

4e. Facility Name (If not institution, give street and number): 10705 Old Annapolis Rd.

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick.

Funeral Director

5. Social Security Number: 132-26-6295

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1932

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 7727 McKaig Rd.

10f. Zip Code: 21701

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): agent

16b. Kind of Business/Industry: insurance

17. Father's Name (First, Middle, Last): James Andrew Wallace, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Loretta Egan

19a. Informant's Name/Relationship (Type, Print): Patricia Wallace/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7727 McKaig Rd. Frederick, MD 21701

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Serv. Date: 1/18/01

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. ASCVD — Approximate Interval: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) field

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D35164

29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, 1080 W. Patrick St. Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02373

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maxine White Warfield

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 7:30am

4a. Facility Name *(If not institution, give street and number)*: Montgomery County General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-42-3656

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 19, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Marriottsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1975 Sand Hill Road

10f. Zip Code: 21104

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Edcetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: English Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Frank Malcolm White

18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Blake

19a. Informant's Name/Relationship *(Type, Print)*: Mr. J. Gordon Warfield (Spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1975 Sand Hill Road Marriottsville, MD 21104

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Goshen Cemetery

Date: 1/15/01

20c. Location - City or Town, State: Laytonsville, MD

21. Signature of Funeral Service Licensee: ▶ Brian L Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER — 15 YEARS

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) snd manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Evelyn Jackson MD

29c. License number: D25947

29d. Date signed *(Month, Day, Year)*: JANUARY 11, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): EVELYN JACKSON, MD 5540 TEN OAKS ROAD, CLARKSVILLE, MD 21029

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02374

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLANCHE I. WALLACE
2. Date of Death: Month 1 Day 14 Year 01
3. Time of Death: 6Am
4a. Facility Name *(If not institution, give street and number)*: MILLENIUM SOUTH RIVER
4b. City, Town, or Location of Death: EDGEWATER
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 578-42-8445
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 29 1919
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LOTHIAN
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 871 BAYARD ROAD
10f. Zip Code: 20711
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FOOD SERVICE
16b. Kind of Business/Industry: ANNE ARUNDEL CO. PUBLIC SCHOOL

17. Father's Name *(First, Middle, Last)*: HOWARD SELLMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: BLANCHE OWENS

19a. Informant's Name/Relationship *(Type, Print)*: EVELYN GROSS (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7507 PLATER LA. GLENDALE, MARYLAND 20769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: ADAMS CHURCH CEMETERY
Date: 1/19/01
20c. Location - City or Town, State: LOTHIAN, MARYLAND

21. Signature of Funeral Service Licensee: ▶Harry D. Reese M000482
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebrovascular accident — 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Multiple decubitus ulcers
Type 2 Diabetes mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶Donna Chambers
29c. License number: D48101
29d. Date signed *(Month, Day, Year)*: 1/16/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donna Chambers 1833A Forest Drive Annapolis MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND: #15 mcg 1/9/2001 AACO HEALTH DEPT

Certificate of Death

Reg. No. 2001 02375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary WYNN

2. Date of Death Month Day Year: January 04 2001

3. Time of Death: 12:25

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NONE

Funeral Director

5. Social Security Number: 213-22-1268

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 15 1916

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 17 COLLEGE AVENUE

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th ~~10TH~~ | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING SERVICE

16b. Kind of Business/Industry: CROWNSVILLE HOSPITAL

17. Father's Name (First, Middle, Last): CLARENCE JOHNSON

18. Mother's Name (First, Middle, Maiden Surname): FLORENCE ADAMS

19a. Informant's Name/Relationship (Type, Print): NANCY JOHNSON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 560 MILLSHIRE DR. MILLERSVILLE, MD. 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ANNAPOLIS MEM. GARDENS

Date: 1/10/01

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: ▶ Larry H. Reese M00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE — 1year

Due to (or as a consequence of):
b. AORTIC STENOSIS — 1year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DIABETES MELLITUS — 10years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): JANUARY 06 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael G. House M.D. Johns Hopkins Hospital, 600 N. Wolfe St

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001

32. Registrar's Signature: ▶ Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02376

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julia W. Woodward
2. Data of Death Month Day Year: January 5, 2001
3. Time of Death: 9:45AM
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-36-7934
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: March 3,1903
9. Birthplace *(State or Foreign Country)*: Texas

Usual Residance of Decedant

10a. Stata: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 6207 River Crescent Drive
10f. Zip Coda: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☐ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): +4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Asst. Director of Testing
16b. Kind of Business/Industry: State of MD, Civil Ser.

17. Father's Nama *(First, Middle, Last)*: Louis E. Walker
18. Mother's Nama *(First, Middle, Maiden Surname)*: Olive M. Bright

19a. Informant's Name/Ralationship *(Type, Print)*: Evans Walker (Nephew)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Box 274 Brownwood, Texas 76804

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Ramovel from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Anne's Cemetery | Data: 1/11/2001
20c. Location - City or Town, Stata: Annapolis, Maryland

21. Signatura of Funeral Service Licansae: Beverly Ann Barlow
22. Name end Addrass of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only ona cause on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death) a.	pneumonia, organism unknown	3 days
Dua to (or as a consaquence of):		
Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or Injury thet initiated events resulting in death) Last b.	upper respiratory infection	5 days
Dua to (or as a consaquance of):		
c.		
Dua to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

pulmonary fibrosis

coronary heart disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To tha best of my knowledga, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at tha tima, deta and place, and dua to the cause(s) and mannar steted.

29b. Signeture end titla of certifiar: Elaine MArata
29c. Licansa number: D45297
29d. Date signad *(Month, Day, Year)*: 1-5-2001

30. Nama end address of person who completed causa of daath (Item 23a) (Type, Print): ELAINE M ARATA 104 RIDGELY AVE. ANNAPOLIS, MD 21401

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 09 2001
32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELEANOR M. YATER
2. Date of Death Month / Day / Year: JAN 09 2001
3. Time of Death: 0545
4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL @ EASTON
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 122-14-4900
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 6, 1923
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: CAROLINE
10c. City, Town or Location: PRESTON
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 7001 GANEYS WHARF RD
10f. Zip Code: 21655
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: FRANK J. TURNER
18. Mother's Name *(First, Middle, Maiden Surname)*: KATHERINE M. TRAINOR

19a. Informant's Name/Relationship *(Type, Print)*: JOSEPH H. YATER, JR/HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7001 GANEYS WHARF RD., PRESTON, MD 21655

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN MEMORIAL PARK — Date: 1-12-01
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: ▶ M. E. Newnam III C.F.S.P.
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

15 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis M DeShields
29c. License number: D0053110
29d. Date signed *(Month, Day, Year)*: 1/9/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DENNIS M. DESHIELDS 219 S. WASHINGTON ST EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

ELEANOR YATER
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 13 per F.D. 01/11/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Herbert Yingling
2. Date of Death (Month, Day, Year): Jan. 10, 2001
3. Time of Death: 8:31 AM
4a. Facility Name (If not institution, give street and number): Westminster Nursing & Convalescent Ctr.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-05-7519
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 1, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 559 Crossbridge Drive
10f. Zip Code: 21158
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Maryland Electric Company

17. Father's Name (First, Middle, Last): Herbert Yingling
18. Mother's Name (First, Middle, Maiden Surname): Lillian Haines

19a. Informant's Name/Relationship (Type, Print): Mabel L. Yingling/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 559 Crossbridge Dr. Westminster, MD 21158

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Carroll Cremations Inc
Date: 01/11/2001
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LARGE RIGHT CEREBROVASCULAR ACCIDENT — 1 month

Due to (or as a consequence of):
b. HYPERTENSION — 30 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ramon K. Galvez III MD
29c. License number: D31660
29d. Date signed (Month, Day, Year): 01/10/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): THOMAS K. GALVEZ MD 291 STONER AVE WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02379

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard Joseph Yealy
2. Date of Death Month Day Year: January 14, 2001
3. Time of Death: 8:45p
4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 177-30-9100
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 11, 1936
9. Birthplace *(State or Foreign Country)*: McSherrystown, PA

Usual Residence of Decedent

10a. State: PA
10b. County: Adams
10c. City, Town or Location: McSherrystown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 332 Main Street
10f. Zip Code: 17344
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Locksmith
16b. Kind of Business/Industry: American Locksmith CO.

17. Father's Name *(First, Middle, Last)*: William A. Yealy
18. Mother's Name *(First, Middle, Maiden Surname)*: Marguerite F. Roth

19a. Informant's Name/Relationship *(Type, Print)*: Diann M. Yealy Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 332 Main St., McSherrystown, PA 17344

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Yorktowne Cremation Service
Date: 1-16-01
20c. Location - City or Town, State: York, PA 17404

21. Signature of Funeral Service Licensee: H. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel 21117
11605 Reisterstown Rd., Owings Mills, Md.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBELLAR CEREBROVASCULAR ACCIDENT — 5DYS

Due to (or as a consequence of):
b. CEREBROVASCULAR DISEASE — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. TYPE 2 DIABETES MELLITUS — YRS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James A. Dicke, MD
29c. License number: D36231
29d. Date signed *(Month, Day, Year)*: 1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES A. DICKE MD 6701 N. CHARLES ST STE 410S BALTO MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G Sparks

To Be Completed by Funeral Director

Yealy, Richard
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02380

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Reita Thompson Avery
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 11:00 PM
4a. Facility Name *(If not institution, give street and number)*: Wesley Home
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 531-07-0072
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 23, 1905
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2211 West Rogers Avenue
10f. Zip Code: 21209
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Otis Thompson
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Roe

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Cathy Korman/ Grand niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2700 Maple Avenue Parkville , Maryland 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp. | Date: 1/30/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Dementia	Years
	Due to (or as a consequence of):	
	b. Arteriosclerotic Vascular Disease	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Seizure Disorder, Hypertension, Coronary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Fleet, MD
29c. License number: D21464
29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD 3508 BANK ST BALTO, md 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8-5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK RICHARD BROWN
2. Date of Death: Month 1 Day 25 Year 2001
3. Time of Death: 10:00AM
4a. Facility Name (If not institution, give street and number): 10222 BENT CREEK ROAD
4b. City, Town, or Location of Death: OCEAN CITY
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 217-24-1020
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-29-30
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10222 BENT CREEK ROAD
10f. Zip Code: 21842
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ESTIMATOR
16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): OSCAR BROWN
18. Mother's Name (First, Middle, Maiden Surname): MARGARET FRANK

19a. Informant's Name/Relationship (Type, Print): BRUCE BROWN / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 WEST END AVE. NEW YORK, NY. 10023

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Meadowridge Memorial Pk.
Date: 1/27/01
20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: ▶ Josh M. Poss
22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or es a consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest
b. Atherosclerosis
Due to (or es e consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcoholism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end placa, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end dua to the cause(s) end manner steted.

29b. Signature and title of certifier: ▶ Victor Gary MD
29c. License number: D32615
29d. Date signed (Month, Dey, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Victor Gary MD 7408 Coastal Hwy OC MD 21842

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001
32. Registrer's Signature: ▶ Jeanne B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Jose Benavent

2. Date of Death — Month: Jan Day: 26 Year: 2001

3. Time of Death: 4:10 pm

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 582-40-0382

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08 21 1923

9. Birthplace (State or Foreign Country): Puerto Rico USA

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 719 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Doctor

16b. Kind of Business/Industry: Private Practice

17. Father's Name (First, Middle, Last): Arturo Benavent

18. Mother's Name (First, Middle, Maiden Surname): Noema Rico

19a. Informant's Name/Relationship (Type, Print): Marie Benavent/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Maiden Choice Lane, Baltimore, Md. 21228

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Wash. Crem

Date: 01/29/01

20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Baltimore, Md. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic cholangiocarcinoma — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Andres Salazar MD

29c. License number: D51051

29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature ▶ Bruce D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Name: Walter Benavent

25+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02383

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WALTER SCOTT CARSWELL, III

2. Date of Death (Month, Day, Year): JANUARY 28, 2001

3. Time of Death: 1:30 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-30-4209

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 19, 1928

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 218 Maryland Ave.

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Superintendent

16b. Kind of Business/Industry: Dulaney Valley Memorial Gardens

17. Father's Name *(First, Middle, Last)*: Walter Scott Carswell, Jr.

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Reba Frances Bickford

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Marion F. Carswell/wife

19b. Mailing Addreas *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 218 Maryland Ave. Towson, Md. 21286

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Hilltop Service Corp. Dete: 1/31/01

20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such aa cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. ACUTE INFERIOR MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the lime, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joginder P Mehta M.D

29c. License number: D 0041410

29d. Date signed *(Month, Day, Year)*: January 29th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrer's Signature: ▶ per D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0448-510

DOLORES

CAPERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02384

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Delores Capers

2. Date of Death (Month, Day, Year): JANUARY 26, 2001

3. Time of Death: 4:40P.M.

4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-38-4026

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-19-41

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2620 East Federal Street

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Custodian

16b. Kind of Business/Industry: City of Baltimore

17. Father's Name *(First, Middle, Last)*: Delbert B. Capers

18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Mae Hannah

19a. Informant's Neme/Relationship *(Type, Print)*: Andre Capers

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2620 E. Federal Street Baltimore, MD 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Date: 01-31-2001

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: Frank Gross

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Pulmonary Thrombo-Embolism

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due fo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Clark

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Penne B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

01-0390-031
jhm
MEGHAN T
COKER AMENDED ITEMS# 23a,27,&28a-f per ME G792 020801 SS

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02385

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Meghan T. Coker

2. Deta of Death — Month: JANUARY Dey: 23, Year: 2001

3. Time of Death: 22:00 PM

4e Facility Name *(If not institution, giva street and number)*: 2904 FRIENDLY WOOD WAY

4b. City, Town, or Location of Deeth: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-17-3164

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthdey)*: 19 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: June 2 1981

9. Birthplace *(Steta or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Burtonsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2904 Friendlywood Way

10f. Zip Code: 20866

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Merried 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+): 2

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Nema *(First, Middle, Last)*: Christopher Coker

18. Mother's Name *(First, Middle, Meiden Surnema)*: Sandra DeLuca

19e. Informent's Neme/Reletionship *(Type, Pnint)*: Christopher Coker Father

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2904 Friendlywood Way Burtonsville, MD 20866

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Mount View Cemetery

Dete: 01/27/01

20c. Location - City or Town, Stete: Marriottsville, MD

21. Signature of Fdneral Service Licensee: [signature]

22. Name and Address of Feclity: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth): e. CONTACT GUNSHOT WOUND OF THE BACK OF THE HEAD

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Pert fl. **Other significant conditions** contributing fo deeth but not rasulting in the underlying ceuse given in Pert I.

23b. Did **tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☒Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No

26. Piece of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Menner of Death: 1☐Neturel 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*: found: 1-23-01

28b. Time of Injury: found 9:50 p

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: subject shot self

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: found: residence

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: 2904 Friendly Wood Way Silver Spring, MD

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the causa(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: [signature] M.D.

29c. Licensa number: OCME

29d. Dete signed *(Month, Dey, Year)*: JANUARY 24, 2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Deta filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signetura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD DERR

2. Date of Death: Month JAN Day 27 Year 2001

3. Time of Death: 6:10 AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 216-36-7455

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 10, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: " " 8740 B Town and Country Blvd.

10f. Zip Code: 21043

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemist

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Frank Derr

18. Mother's Name (First, Middle, Maiden Surname): Camilla Peterson

19a. Interment's Name/Relationship (Type, Print): Jacqueline Derr- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8740 "B" Town and Country Blvd. Ellicott City, Md. 21043

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTO/WASHINGTON CREMATORY

Date: 01/30/2001

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Jennifer Scherr

22. Name and Address of Facility: Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Colimbia, Maryland 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deputy ME

29c. License number: D31473

29d. Date signed (Month, Day, Year): Jan 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICK A. JOYCE MD 9565 Hemlock Cove Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Helen J. Eller	January 28, 2001	5:00 AM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8317 Carrbridge Circle	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
334-20-6932	1☐M 2☒F	73 Yrs.					8-28-1927	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Towson	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8317 Carrbridge Circle	21204	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Vincent O'Brien	Helen Monique Tower

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. John W. Eller (Husband)	8317 Carrbridge Circle, Towson, Maryland 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	1-30-01	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wallace S Brooks, Jr	Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	5½ years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul Celano, MD	D30929	1/29/2001

30. Name and address of person who completed cause of death (Item 23e) (Type-Print)
PAUL CELANO, MD 6565 N. Charles ST, Baltimore MD 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 31 2001	▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0466-510
m.n.m.r
Tristan Filbert

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02388

AMENDED ITEMS# 23a,b,& 27 per ME G792 022001 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tristan Conrad Filbert
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 0822 am
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216.47.0679
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 4 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 12,1996
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Elkridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5833 Timberview Drive
10f. Zip Code: 21075
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): H. Conrad Filbert
18. Mother's Name (First, Middle, Maiden Surname): Lisa Benny

19a. Informant's Name/Relationship (Type, Print): H.Conrad Filbert/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5833 Timberview Dr. Elkridge,MD 21075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem.Park
Date: 2/1/01
20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: Gary L. Peters
22. Name and Address of Facility: Gary L. Kaufman Funeral Home 7250 Washington Blvd. Elkridge MD 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY ARREST
Due to (or as a consequence of):
CHYLOTHORAX ASSOCIATED WITH INTESTINAL LYMPHANGIECTASIA AND OPITZ BBB SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chute
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 3 1 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Fleet

2. Date of Death (Month, Day, Year): Jan. 28, 2001

3. Time of Death: 6:15pm

4a. Facility Name (If not institution, give street and number): Genesis Elder Care Multi-Med. Ctn.

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-38-6059

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09-27-42

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No XX

10e. Street and Number: 3416 Woodstock Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): High Sch. Grad

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Case Manager

16b. Kind of Business/Industry: City of Baltimore

17. Father's Name (First, Middle, Last): Sam Charles

18. Mother's Name (First, Middle, Maiden Surname): Margaret Flowers

19a. Informant's Name/Relationship (Type, Print): Nailah Rooks&Francine Phillips

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3416 Woodstock Avenue Baltimore, MD 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk. Cem.

Date: 02-01-2001

20c. Location - City or Town, State: Randallstown, MD.

21. Signature of Funeral Service Licensee: Darrell L. Hunter

22. Name and Address of Facility: Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery disease

Due to (or as a consequence of):

b. Brittle Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Renal insufficiency

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral ulcer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 31464

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHOAIB A. HAQ MD, 821 N. Eutaw St Suite 308, Balt. MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ENAMAY JOSEPHINE GOLDSTRAW

2. Date of Death (Month, Day, Year): JANUARY 20, 2001

3. Time of Death: 11:25 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-26-8319

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 6, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockesyville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10105 Cardington Way

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: unk (1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced)

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): registered nurse

16b. Kind of Business/Industry: health

17. Father's Name (First, Middle, Last): Walter Harry Pikey

18. Mother's Name (First, Middle, Maiden Surname): Thelma Estelle Gordon

19a. Informant's Name/Relationship (Type, Print): Gilchrist Center

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6601 N. Charles Street Baltimore, MD 21204

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Enamay Goldstraw 11:25a.m. 1/20/01

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon cancer — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M. Gordon MD

29c. License number: D0051926

29d. Date signed (Month, Day, Year): Jan. 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon MD 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN M. GILBERT
2. Date of Death (Month, Day, Year): 01 28 2001
3. Time of Death: 11:30am
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 220.20.1874
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 13, 1927
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Crownsville
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 1302 Eva Gude Drive
10f. Zip Code: 21032
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Angelo Gregg
18. Mother's Name (First, Middle, Maiden Surname): Josephine Treater

19a. Informant's Name/Reletionship (Type, Print): Peter Gilbert/Husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1302 Eva Gude Drive Crownsville, MD 21032

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removel from Stete XX 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Meadowridge Mem. Park
Date: 2/1/01
20c. Location - City or Town, Stete: Elkridge, MD

21. Signature of Funeral Service Licensee: Kathryn Peters
22. Name and Address of Facility: Gary L. Kaufman Funeral Home 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. LUNG METASTASIS

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Mark G Saba MD
29c. License number: p13407
29d. Date signed (Month, Dey, Year): 1/28/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK G. SABA, 225 Greene St., Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Suzanna May Groenheim

2. Date of Death (Month, Day, Year): Jan 28, 2001

3. Time of Death: 6:30 am

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 203-14-0728

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 19, 1907

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administratine Secretary

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Arnold Bierman

18. Mother's Name (First, Middle, Maiden Surname): Suzanna Simons

19a. Informant's Name/Relationship (Type, Print): Henri A. Groenheim-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 526 St. Francis Road, Towson, Maryland 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Lebanon Cem.

Date: 1/31/2001

20c. Location - City or Town, State: Queens, New York

21. Signature of Funeral Service Licensee: Bernard Balmer

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. End Stage Dementia — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: Andres Salazar MD

29c. License number: D 51051

29d. Date signed (Month, Day, Year): January 28, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar, 711 Maiden choice Lane, Catonsville, MD, 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Name: Suzanna Groenheim

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM #19b per fh G791 013101 ss

Certificate of Death

Reg. No 2001 02393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Green

2. Data of Death Month 01 Day 25 Yaar 2001

3. Tima of Death: 1:35p.m.

4a. Facility Nama (If not institution, giva street and number): Blue Point N/H.

4b. City, Town, or Location of Death: Baltimore

4c. County of Daath: NA

Funeral Director

5. Social Security Number: 217-24-9432

6. Sex 1 X M 2 ☐ F

7. Aga (In yrs. last birthday): 71 Yrs.

If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.

8. Data of Birth (Month, Day, Yaar): 04 23 29

9. Birthplace (State or Foraign Country): M.D.

Usual Residence of Decedent

10a. Stata: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: X 1 Yes 2 ☐ No

10e. Street and Number: 8 Plater Ct.

10f. Zip Coda: 21207

10g. Citizan of Whal Country? U.S.A

11. Maritaf Status: 1 ☐ Never Married 2 ☐ Married X 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 X No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12th grade; Collega (1-4or 5+): na

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Bus Driver

16b. Kind of Business/Industry: M.T.A.

17. Father's Name (First, Middle, Last): Ernest Green

18. Mothar's Nama (First, Middla, Maidan Sumama): Lucille Coates

19a. Informant's Name/Ralationship (Type, Print): Ernest Green-Father

19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda): 656 Revell Hight Way. ~~Aannapolis,~~ Annapolis Md 21401

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Garrison Forest Vet. Data 2/1/01

20c. Location - City or Town, Stala: Owings Mills, Md

21. Signatura of Funeral Sarvice Licensee: Glynnis B. Keke

22. Nama and Addrass of Facility: March F. H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part 1. Entar tha disease, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hean failure. List only ona cause on each line. Approximate Intarval Batwaan Onsat and Daath

Immediata Cause (Finat disease or condition resulting in death): a. AIDS

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last:

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☐ No 9 ☐ Unknown

23c. If yes, outcoma of pregnancy 1 ☐ Live birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at tima of death 5 ☐ Othar (specify) 9 ☐ Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying causa givan in Part I.

23a. Did tobacco use contributa to tha causa of daath? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No

24b. Wara autopsy findings availabla prior to compilation of cause of daath? 1 ☐ Yas 2 ☐ No

25. Was case rafarrad to medical axaminer? 1 ☐ Yas 2 ☐ No

28. Place of Daath (Chack only ona): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 8 ☐ Othar (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streal, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)

29a. Certifier (Check only one): 1 X Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: MD

29c. License number: 11940

29d. Date signed (Month, Day, Yaar): JAN. 27, 2001

30. Nama and addrass of parson who completed cause of daath (Item 23a) (Type, Print): [illegible] SUNSHINE, MD 6210 Kenhurst Ave, Balto, MD 21215

State Registrar

31. Data filed (Month, Day, Yaar): JAN 31 2001

32. Registrar's Signatura: Lenora G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02394

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vernon Marshall Hopkins, Sr.

2. Date of Death — Month: January Day: 11 Year: 2001

3. Time of Death: 1225

4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 725-16-4112

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov.25,1929

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Ridgely

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 23851 Seward Road

10f. Zip Code: 21660

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Eaucetion *(Specify only highest grada completad)*: Elementary/Secondery (0-12): 6 — College (1-4or 5+):

16a. Decedent's Uauel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Automotive

17. Father's Neme *(First, Middle, Last)*: Charles E. Hopkins

18. Mother's Neme *(First, Middle, Maiden Surname)*: Flossie Oertly

19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Patricia L. Wright

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23851 Seward Road Ridgely, Maryland 21660

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hopkins Family Cemetery — Date: Jan.16,2001

20c. Location - City or Town, Stete: Woodbridge, VA

21. Signature of Funeral Service Licensee: [signature]

22. Neme end Address of Fecility: Mountcastle Funeral Home 4143 Dale Blvd. Dale City, Virginia 22193

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in deeth) a.	Myocardial Infarction - Sudden Death	2 hours
Due to (or es a consequence of):		
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Coronary Artery Disease	10yrs
Due to (or es a consequence of):		
c.	Hyperlipidemia	40yrs
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D47492

29d. Date signed *(Month, Day, Year)*: 1/12/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Jeffrey T. Denton, MD 555 Cynwood Drive Easton, Maryland 21601

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Vernon Hopkins

WR WD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#30 perDVRG791 1/31/2001 EW

Certificate of Death

Reg. No. 2001 02395

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Marjorie Hansen

2. Dete of Deeth — Month: 01 Dey: 14 Year: 2001

3. Time of Death: 12:01 AM

4e. Facility Neme (If not Institution, give street end number): Rockville Nursing Home

4b. City, Town, or Location of Deeth: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Socte! Security Number: 577-34-1245

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): Jan 21, 1921

9. Birthplece (State or Foreign Country): Iowa

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limtle: 1☐Yes 2☒No

10e. Street end Number: 303 Adclare Road

10f. Zip Code: 20850

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐Never Merrted 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): information librarian

16b. Kind of Business/Industry: private industry

17. Father's Neme (First, Middle, Last): James H. McKee

18. Mother's Neme (First, Middle, Meiden Surneme): Margaret Emery

19e. Inlorment's Neme/Reletionship (Type, Print): Nancy Groom/daughter

19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1009 Robin Road Silver Spring, MD 20901

20a. Method of Disposition: 1☐Buriat 2☐Cremetion 3☐Removel from Stete 4☒Donetion 5☐Other (Specify)

20b. Plece ol Dispositon (Neme of cemetery, cremetory or other piece)

Dete

20c. Location - City or Town, Stete

21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director

22. Neme end Address ol Feciity: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onsel end Deeth

Immedlete Cause (Finel diseese or condition resulting in death)

e. Stroke

Due to (or es a consequence ol):

Sequentially list conditions, if eny, leeding to immedlete cause. Enter Underlying Ceuse (Diseese or Injury thet tnitieted events resulting in death) Lest

b. arteriosklerosis — 1 year

Due to (or es a consequence ol):

c. Diabetes Mellitus II — years

Due to (or as e consequence of):

d.

Part II. Other slgnificant conditlona contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causes of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings avellable prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case relerred to medical exeminer? 1☐Yes 2☒No

26. Plece of Deeth (Check only one): Hospital: 1☐Inpetlenl 2☐ER/Outpetlenl 3☐DOA Other: 4☒Nursing Home 5☐Restdence 6☐Other (Specify)

27. Menner ol Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece ol Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28l. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best ol my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) end menner steted.

29b. Signeture end litle ol certiller: ▶ Frauke Westphal MD

29c. License number: D 19785

29d. Dete signed (Month, Dey, Year): 1/22/01

30. Neme end address of person who completed cause ol deeth (Item 23a) (Type, Print): Frauke Westphal 5104 Wickett Terrace Bethesda, Md 20014

State Registrar

31. Dete filed (Month, Day, Year): JAN 31 2001

32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Iola C. Head

2. Date of Death: Month JANUARY Day 30 Year 2001

3. Time of Death: 10:00 AM

4a. Facility Name (If not institution, give street and number): 5108 Shelbourne Avenue

4b. City, Town, or Location of Death: Arbutus

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218.62.1384

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 27, 1912

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5108 Shelbourne Avenue

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Willie Covington

18. Mother's Name (First, Middle, Maiden Surname): Parthenia Peatross

19a. Informant's Name/Relationship (Type, Print): James E. Head, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5701 Green Valley Place, Elkridge, MD 21075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Meadowridge Mem. Park

Date: 2/2/01

20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: Gary L. Kaufman

22. Name and Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge Memorial Park, Inc. 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CEREBROVASCULAR ACCIDENT	1 week
Due to (or as a consequence of):	b. SEVERE CEREBROVASCULAR INSUFFICIENCY	6 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. GENERALIZED ATHEROSCLEROSIS	10 years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PREVIOUS MULTIPLE STROKES. REFRACTORY ATRIAL FIBRILLATION. CORONARY HEART DISEASE. MULTI-INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN

29c. License number: D16200

29d. Date signed (Month, Day, Year): JANUARY 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORBERTO M. MACHIRAN, M.D. 720-C MAIDEN CHOICE LA. BALTO. MD. 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NATHANIEL Hicks JR.

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 11:52 AM.

4a. Facility Name (If not institution, give street and number): Joseph Richie Hospice House

4b. City, Town, or Location of Death: BALTO. MD.

4c. County of Death: N/A.

Funeral Director

5. Social Security Number: 214-56-5602

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 27, 1952

9. Birthplace (State or Foreign Country): S.C

Usual Residence of Decedent

10a. State: MD. | 10b. County: N/A. | 10c. City, Town or Location: BALTO. | 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4504 Bayonne Ave | 10f. Zip Code: 21206 | 10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 grade | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: TRUCK DRIVER

17. Father's Name (First, Middle, Last): NATHANIEL HICKS SR.

18. Mother's Name (First, Middle, Maiden Surname): Willie Lee Hicks

19a. Informant's Name/Relationship (Type, Print): DEBRA T. HICKS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4504 Bayonne Ave. BALTO. MD 21206

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEM | Date: 2-1-2001

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: Betts Funeral Home 1129 N. Eastern St. BALTO. MD. 21213

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Esophageal cancer with mets — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Payne MD

29c. License number: D13012

29d. Date signed (Month, Day, Year): Jan 28, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne 6505 N. Charles St 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: D. Spoede

DHMH 16 Rev 6/95

ORIGINAL

JANUARY 27, 2001 11:52 AM

NATHANIEL HICKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02398

Hierstetter, Stephanie
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephanie Helen Hierstetter

2. Data of Death: Month January Day 26 Year 2001

3. Time of Death: 2:38 pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-07-6415

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 21, 1920

9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Dacedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Streef and Number: 3509 Washington Avenue

10f. Zip Coda: 21244

10g. Citizen of What Country?: United States

11. Marifal Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade compilated)
Elementery/Secondery (0-12): 8 Years
Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): John Laszczynski

18. Mothar's Neme (First, Middle, Meidan Surnama): Theresa Buchinska

19a. Informant's Name/Relationship (Type, Print): Mr. Wayne Hierstetter (Son)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 7925 Lynch Road Dundalk, Maryland 21222

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☒ Othar (Specify): Entombment

20b. Place of Disposition (Neme of cemetery, crametory or othar place): Sacred Ht. of Jesus Cem.

Date: 1/30/2001

20c. Location - City or Town, Stata: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Donald W. Ruck

22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)
a. Ischemic colitis — 48 hours
Due to (or as a consequance of):
b. Embolic Atrial Fibrillation
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as a consequance of):
d.

Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I.

Congestive Heart Failure

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings available prior to complation of causa ot death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner? 1☒ Yas 2☐ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding Invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to tha cause(s) and manner as stated. 2☐ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, date end place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: [illegible], MD

29c. License number: AT2438946

29d. Data signed (Month, Day, Year): 01/26/2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): BRIAN TIPPETT 1309 REDBRIDGE DRIVE SEVERN, MD 21144

State Registrar

31. Data filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02399

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Rita Hart

2. Date of Death Month / Day / Year: January 27, 2001

3. Time of Death: 1:26 AM

4a. Facility Name *(If not institution, give street and number)*: Perring Parkway Nursing Home

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 215-18-7663

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 25, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1801 Wentworth Avenue

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accounting Clerk

16b. Kind of Business/Industry: State of Maryland

17. Father's Name *(First, Middle, Last)*: Francis Kaufman

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Harrington

19a. Informant's Name/Relationship *(Type, Print)*: Carol A. Hart/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 60605 Jacksonville, Florida 32236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 2/01/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton

Christina L. Hilton

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. dehydration

Due to (or as a consequence of):

c. dementia.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hx CHF, CAD.

Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rachelle [illegible], MD

29c. License number: D0056705

29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RACHELLE GAJADHAR 2007 E. Northern Parkway, Baltimore, MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02400

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter E. Henderson

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 3:25 P.M.

4a. Facility Name (If not institution, give street and number): 2 Summit Hill Court #B3

4b. City, Town, or Location of Death: Catonsville MD.

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-16-9884

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06-01-1923

9. Birthplace (State or Foreign Country): Baltimore

Usual Residence of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2 Summit Hill Court #B3

10f. Zip Code: 21228

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Insurance Claims Supervisor

16b. Kind of Business/Industry: Allstate Insurance

17. Father's Name (First, Middle, Last): Walter E. Henderson

18. Mother's Name (First, Middle, Maiden Surname): Anna F. Nagle

19a. Informant's Name/Relationship (Type, Print): Thelma M. Henderson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Summit Hill Court #B3 Catonsville MD. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MeadowRidge Memorial Park

Date: 2-2-01

20c. Location - City or Town, State: Elkridge MD.

21. Signature of Funeral Service Licensee: ▶ Brenda L Lemmer

22. Name and Address of Facility: Witzke Funeral Home of Catonsville 1630 Edmondson Ave. Catonsville MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic non-small cell carcinoma, lung — 8 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary thromboembolism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William J Hicken, M.D.

29c. License number: D0004964

29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM J HICKEY, M.D., St. Agnes HealthCare, Baltimore, Md.

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Walter E. Henderson

1 of 1

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02401

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wesley Harbison

2. Date of Death (Month, Day, Year): January 23, 2001

3. Time of Death: 2:30 AM

4a. Facility Name (If not institution, give street and number): Bon Secours Hosprtal

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 423-34-7747

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 18, 1909

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3212 W. Normount Ave.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8; College (1-4or 5+): 8

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Construction

17. Father's Neme (First, Middle, Last): Joe W. Harbison

18. Mother's Neme (First, Middle, Meiden Surname): Daisy Harbison

19a. Informent's Neme/Reletionship (Type, Print): (nephew) Mr. James Harbison

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3212 W. Normount Ave. Balto. Md. 21216

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Garrison Forest

Dete: 1/31/2001

20c. Location - City or Town, Stete: Owings Mills, Md

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Neme end Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in deeth)

a. Pneumonia — Due to (or as a consequence of): — 3 day

b. Stroke — Due to (or es a consequence of): — 10 yr

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

c. — Due to (or as e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Renal failure

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one): Hospitel: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signature end title of certifier:

29c. License number: D25044

29d. Date signed (Month, Day, Year): 1/31/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): M. REDMOND MD 2717 HAMMONDS FERRY Rd 21227

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001

32. Registrer's Signeture: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02402

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geneva W. Johnson

2. Date of Death (Month, Day, Year): JANUARY 27, 2001

3. Time of Death: 3 29 PM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice At Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-09-3836

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-26-1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 600 Light Street #723

10f. Zip Code: 21230

10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Baltimore Federal Savings & Loans

17. Father's Name (First, Middle, Last): Edward Howard Walker

18. Mother's Name (First, Middle, Maiden Surname): Mary Geneva Burgan

19a. Informant's Name/Relationship (Type, Print): Mr. Benjamin A. Johnson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 Light Street #723. Baltimore, Maryland

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 1-30-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ Wallace S. Brooks, Jr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Probable Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D40854

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE Md 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: ▶ [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02403

Jones, Gussie

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gussie Jones
2. Date of Death — Month: January Day: 26 Year: 2001
3. Time of Death: 1820
4a. Facility Name *(If not institution, give street and number)*: Dayton Umms
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 189-16-3560
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 10, 1910
9. Birthplace *(State or Foreign Country)*: S. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 715 Allendale St.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondary (0-12): 7th — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sewing
16b. Kind of Business/Industry: Factory

17. Father's Name *(First, Middle, Last)*: Henry Harvin
18. Mothar's Name *(First, Middle, Maiden Surname)*: Irene Wells

19a. Informant's Name/Relationship *(Type, Print)*: Louise Jenkins - niece
19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 715 Allendale St. Balto, MD. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: White Chapel Cemetery — Data: 2-3-01
20c. Location - City or Town, State: Feasterville Co., PA.

21. Signature of Funeral Service Licensee: ▶ Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 240 Fredhiton Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC FAILURE — 3 Weeks
Due to (or as a consequence of): ATRIAL FIBRILLATION — 3+ MONTHS
Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaase or injury that initiated events rasulting in daath) Last:
b. Due to (or as a consequenca of):
c. Due to (or as e consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: ANAPLASTIC CARCINOMA THYROID, DEMENTIA, PERIPHERAL VASCULAR DISEASE, BLINDNESS

23b. Did tobacco use contribute to the ceuae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowladga, daath occurrad at the time, date and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James P. Flynn MD
29c. License number: D01346
29d. Date signed *(Month, Day, Year)*: Jan 29 '01

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print): JAMES FLYNN, MD, DEATON SPECIALTY HOSPITAL / HOME 611 S CHARLES ST. BALTIMORE MD 21230

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrer's Signature: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02404

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BEN KOBIN

2. Date of Death Month / Day / Year: January 24 2001

3. Time of Death: 10:07 Am

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 220-03-0005

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 15, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 2827 Marnat Road

10f. Zip Code: 21209

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: pharmacist

16b. Kind of Business/Industry: medicine

17. Father's Name *(First, Middle, Last)*: Joseph Kobin

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Union

19a. Informant's Name/Relationship *(Type, Print)*: David Kobin/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10024 Inkpen Place Ellicott City, MD 21042

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease — 20 years

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Insuffiency (chronic type)

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: Res 000

29d. Date signed *(Month, Day, Year)*: January 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajiv Doshi MD Sinai Hospital of Baltimore 2401 West Belvedere Ave Baltimore MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

PT Known as Ben Kobin

01-0430-510
LRB
MARCUS LYNCH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02405

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marcus Eugene Lynch
2. Date of Death Month / Day / Year: January 25, 2001
3. Time of Death: 10:43 P.M.
4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: Unknown
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 17 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: December 2, 1983
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedant

10a. State: MD
10b. County: N/A.
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2112 E. Federal ST.
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown — College (1-4 or 5+): N/A.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student
16b. Kind of Business/Industry: Student
17. Father's Name *(First, Middle, Last)*: Theodore Lynch
18. Mother's Name *(First, Middle, Maiden Surname)*: Brenda M. Watson
19a. Informant's Name/Relationship *(Type, Print)*: Brenda Coleman Fuller
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1746 Abbottson ST. BALTO. MD. 21218
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: MT. Zion Cem.
Data: 2-2-01
20c. Location - City or Town, State: BALTO. MD.
21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1125 N. Caroline ST. BALTO. MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*: 1-25-01
28b. Time of Injury: 2113 P M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject shot
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1200 Maple Leaf Ct Baltimore, Md

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chutenw
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutenw 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02406

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eul Y. Lee

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 12:14 AM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-06-3168

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 23, 1924

9. Birthplace *(State or Foreign Country)*: Korea

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10331 Lombardi Drive

10f. Zip Code: 21042

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Kiuk Sung

18. Mother's Name *(First, Middle, Maiden Surname)*: Jung Won Kim

19a. Informent's Name/Relationship *(Type, Print)*: Yong Lee - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10331 Lombardi Dr., Ellicott City, Md. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Glen Haven Cemetery

Date: 1/27/01

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funaral Service Licensee: ▶ Mgt C. Mayhew

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

e. SEPSIS — 5 DAYS

Dua to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequenca of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

Hypernatremia

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lydia Wolf

29c. Licanse number: AT24389 46-A10

29d. Date signed *(Month, Day, Year)*: JANUARY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LYDIA WOLF UNION MEMORIAL HOSPITAL 201 E. University Pkwy. BALTIMORE, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02407

LANGIS, GILBERT E 01-18-01 5A

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Gilberte Anita Langis	January 28, 2001	5:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hospice of Baltimore at Gilchrist Center	Towson	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-52-7798	1☐ M 2☒ F	94 Yrs.			September 9, 1906	Massachusetts

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Parkville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8800 Walther Blvd. Apt. 3309 Westwood	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	At Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Adjutor Dupuis	Rose Delima Chabot

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Ronald G. Langis (Son)	1375 Wilson Point Road Middle River, Maryland 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parkwood Cemetery	2/2/2001	Baltimore Maryland

21. Signature of Funeral Service Licensee: ▶ Ronald Ruck Jr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ischemic cardiomyopathy	1 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balt., MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 31 2001	▶ per B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN TUDOR LANGHEIM
2. Date of Death (Month, Day, Year): JAN 29 2001
3. Time of Death: 9:40AM
4a. Facility Name (If not institution, give street and number): 1614 ROSS ROAD
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 215-03-4196
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 20, 1911
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1614 Ross Road
10f. Zip Code: 21050
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cord supervisor
16b. Kind of Business/Industry: Telephone manufacture

17. Father's Name (First, Middle, Last): William Edward Tudor
18. Mother's Name (First, Middle, Maiden Surname): Barbara Shreffer

19a. Informant's Name/Relationship (Type, Print): Sherry Hammen-niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1614 Ross Rd., Forest Hill, MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 1/31/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: William G. Dau
22. Name and Address of Facility: Leonard J. Ruck Funeral Home, INc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final diseese or condition resulting in death): a. A S C J D

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in deeth) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMERS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed (Month, Day, Year): JAN 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G PRABHU MD 728 BEAIR RD BEAIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrer's Signeture:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James E. Mckee

2. Date of Death: Month January Day 29, Year 2001

3. Time of Death: 2:14 PM

4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234-12-5552

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06/06/1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 111 West Road

10f. Zip Code: 21204

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 9/1941 10/1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): Unknown

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown

16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Father John Pfannenstiel /Priest

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4504 Park Heights Ave., Baltimore, Maryland 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA Ceme.

Date: 02/02/01

20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 8-9days

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Resident

29c. License number: P14669

29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald Polinsky Baltimore VA Medical Center, Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: [signature] D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Virginia McNamara

2. Date of Death: Month January Day 28, Year 2001

3. Time of Death: 12:49 AM

4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-01-0656

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/21/1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5549 Ashbourne Rd.

10f. Zip Code: 21227

10g. Citizen of What Country? United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Line Worker

16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): Albert Chaillou

18. Mother's Name (First, Middle, Maiden Surname): Margaret Young

19a. Informant's Name/Relationship (Type, Print): Virginia Shappell/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5549 Ashbourne Rd. Arbutus , Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 02/01/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stan Lubold

22. Name and Address of Facility: 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 Ambrose Funeral Home, Inc

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia — Approximate Interval: 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Payne, MD.

29c. License number: D1301 2

29d. Date signed (Month, Day, Year): JAN 28, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W Payne 0505 N. Charles St. 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Helen Virginia McNamara 1/28/01 12:49 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Adam Miceli
2. Date of Death (Month, Dey, Yeer): January 29, 2001
3. Time of Death: 12:10 PM
4a. Facility Name (If not institution, give street and number): 9104 Covered Bridge Road
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-50-0903
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 51 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year):
9. Birthplace (State or Foreign Country):

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9104 Covered Bridge Road
10f. Zip Code: 21234
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+): 4 Years
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurant Manager
16b. Kind of Business/Industry: Management Food Industry

17. Father's Neme (First, Middle, Last): Thomas John Miceli
18. Mother's Name (First, Middle, Meiden Surname): Lillian Winiecki

19a. Informant's Name/Relationship (Type, Print): Pat Cromer (Sister)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9104 Covered Bridge Road Parkville, MD 21234

20e. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Sacred Ht. of Jesus Cem.
Dete: 2/2/2001
20c. Location - City or Town, State: Dundalk, MD

21. Signeture of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Fecility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deith. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in deeth)
a. Stage IV SQUAMOUS CELL LUNG CANCER — 5 months
Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 ☒ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Menner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete and piece, and due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner**: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end manner steted.
29b. Signeture and title of certifier: S. Sivasailam MD
29c. License number: D45530
29d. Date signed (Month, Day, Year): JANUARY, 29TH, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. SIVASAILAM MD, 6830 hospital drive, SUITE 206, MD - 21237.

State Registrar

31. Dete filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signeture: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Oscar Adolph Robert Milker, Jr.

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 11:00 AM

4a. Facility Name (If not Institution, give street and number): 34 Shipway

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-52-1831

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6, 1951

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 34 Shipway

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): 4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Buyer

16b. Kind of Business/Industry: United Container Machinery

17. Father's Name (First, Middle, Last): Oscar Adolph Robert Milker, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Gladys Hagy

19a. Informant's Name/Relationship (Type, Print): Mrs. Nancy Milker (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 34 Shipway Dundalk, Maryland 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 1/31/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Ventricular fibrillation	sudden
Due to (or as a consequence of): b.	Congestive Cardiomyopathy	10yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hypertension	10 years
Due to (or as a consequence of): d.	Aortic Regurgitation	10 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Perez-Mera

29c. License number: D10613

29d. Data signed (Month, Day, Year): 1-30-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAFAEL PEREZ-MERA 404-406 EASTERN BLVD. BALTIMORE MD 21221

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02413

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Minderlein

2. Data of Death Month: 1 Day: 27 Yaar: 01

3. Tima of Death: 3:00 pm

4a. Facility Nema (If not institution, giva street and number): Lorien - Columbia

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Numbar: 064-09-2027

6. Sex: 1☐ M 2☑ F

7. Aga (In yrs. last birthday): 90 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dela of Birth (Month, Day, Yaar): 8-19-1910

9. Birthplace (State or Foraign Country): Md.

Usual Rasidance of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Eldersburg

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 5816 Oakland Rd.

10f. Zip Coda: 21784

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Naver Married 2☐ Marriad 3☒ Widowed 4☐ Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Dacedant's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 10 / Collega (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Claims Adjuster

16b. Kind of Businass/Industry: Fireman's Fund

17. Father's Nema (First, Middla, Last): Raymond G. Flaherty

18. Mothar's Nama (First, Middla, Maidan Surname): Catherine Covahey

19a. Informant's Name/Relationship (Type, Print): Mrs. Dorothy Crawford/daughter

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 5816 Oakland Rd. Eldersburg, Md. 21784

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donetion 5☐ Othar (Spacify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Most Holy Redeemer

Data: 1/30/01

20c. Location - City or Town, Stata: Baltimore, Md.

21. Signatura of Funeral Service Licensee:

22. Nama and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in daath)

a. Acute Respiratory failure

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated events resulting in daath) Lest

b. Aspiration Pneumonia

Dua to (or as a consequance of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

Acute renal failure

23b. Did tobacco usa contributa to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings availabla prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa raferrad to medical examinar? 1☐ Yas 2☒ No

28. Placa of Daath (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, death occurrad at the tima, data and place, and dua to the cause(s) and mannar statad.

29b. Signatura and tilla of certifier: H Feng, MD

29c. Licansa number: D31927

29d. Data signed (Month, Day, Yaar): January 29th 2001

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print): Ho-Lai Feng, MD Two Knoll North Dr. Columbia, MD 21045

State Registrar

31. Data filed (Month, Day, Yaar): JAN 31 2001

32. Registrar's Signatura: Lenore B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gaetana Montalbano

2. Date of Death — Month: January; Day: 29; Year: 2001

3. Time of Death: 10:30pm

4a. Facility Name (If not institution, give street and number): St Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-34-6897

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): March 4, 1901

9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 601 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): Edward E. Sala

18. Mother's Name (First, Middle, Maiden Surname): Concetta Gerace

19a. Informant's Name/Relationship (Type, Print): Mr. Anthony Sala (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2309 Weathervane Road Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National Cemetery

Date: 2/1/2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: ▶ Michael J. Ruck Sr

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure — 1 year

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: P13597

29d. Date signed (Month, Day, Year): January 29 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Martins (GWU-Dilce Dept of Medicine, 900 Caton Ave Baltimore

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME Montalbano Gaetana

AA-4

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02415

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Louise Moore

2. Data of Death (Month, Day, Yaar): January 28 2001

3. Tima of Death: 7:25 AM

4a. Facility Nama *(If not institution, giva street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 224-50-2368

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: 12-24-23

9. Birthplaca *(Stata or Foraign Country)*: VA.

Usual Rasidance of Decedent

10a. Stata: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yas 2☐ No

10a. Straet and Number: P.O. Box #7238

10f. Zip Coda: 21218

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad

12. Was Decadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* Black

15. Decadant's Education *(Specify only highast grada completad)*: Elamantary/Sacondary (0-12): 6th Grade; Collaga (1-4or 5+): NA

16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retirad)*: Domestic

16b. Kind of Businass/Industry: in & out of home

17. Fathar's Nama *(First, Middla, Last)*: Aron Law

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Eulah Patterson

19a. Informant's Nama/Ralationship *(Typa, Print)*: Shirley Best

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 606 D. Cherrycrest Road Baltimore, MD. 21225

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, crematory or othar placa)*: Voshell Mem. Gardens

Data: 02-03-01

20c. Location - City or Town, Stata: Dundalk, MD

21. Signatura of Funaral Sarvica Licansaa: Darrell L. Hunter

22. Nama and Addrass of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hart failura. List only ona causa on aach lina.

Approximate Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. pneumonia — 2 weeks

Dua to (or as a consaquanca of):
b. lung cancer — 2 years

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last
c.

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

congestive heart failure
Renal failure

23b. Did tobacco usa contributa to tha causa of daath? 1☐ Yas 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compiation of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only ona)*: 1☒ **Cartifying Physician:** To tha bast of my knowladga, daath occurrad at the tima, data and placa, and due to the causa(s) and manner as stated. 2☐ **Madical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and due to the causa(s) and manner stated.

29b. Signatura and titla of cartifiar: [signature], MD

29c. Licansa number: D00555-68

29d. Data signad *(Month, Day, Yaar)*: January, 28 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Typa, Print): INNA KATS, M.D. Union Memorial Hospital, Baltimore, MD 21218

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 31 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nannie Miles
2. Date of Death: Month 01 Day 26 Year 01
3. Time of Death: 1128A
4a. Facility Name (If not institution, give street and number): MANOR CARE
4b. City, Town, or Location of Death: B. TOWSON
4c. County of Death: Balto.

Funeral Director

5. Social Security Number: 239-60-4214
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/22/1938
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md
10b. County: N.A
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4131 The ALAMEDA
10f. Zip Code: 21218
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Worker
16b. Kind of Business/Industry: Fort Meade

17. Father's Name (First, Middle, Last): David Williams
18. Mother's Name (First, Middle, Maiden Surname): Ovella Rogers

19a. Informant's Name/Relationship (Type, Print): Eric Miles
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4131 The ALAMEDA Balto. Md. 21218

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Greenmount Cem
Date: 2/1/01
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph G. Locks Jr
22. Name and Address of Facility: Joseph G. Locks Jr F/H 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	Secs
Due to (or as a consequence of): b.	Ventricular Fibrillation	Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Pulmonary Emboli	Hours
Due to (or as a consequence of): d.	Deep Vein Thrombosis	Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: H47281
29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 E. University Pkwy Baltimore 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: James D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Nannie Miles
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02417

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Laura Moore

2. Date of Death Month / Day / Year: January 28 2001

3. Time of Death: 1035 AM

4a. Facility Name *(If not institution, give street and number)*: Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 215-05-3905

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 17 1911

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6715 Duluth Ave.

10f. Zip Code: 21222

10g. Citizen of What Country?: U.S. of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Kwiatkoski

18. Mother's Name *(First, Middle, Maiden Surname)*: Magdalena Warzecha

19a. Informant's Name/Relationship *(Type, Print)*: Stella Mierzwinski (Sister)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6719 Duluth Ave. Baltimore, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park

Date: Feb. 1,2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mark A Chojnacki

22. Name and Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction — days

Due to (or as a consequence of):
b. coronary artery disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Antonia Bunce, MD

29c. License number: 20300

29d. Date signed *(Month, Day, Year)*: January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Antonia Bunce Bayview Medical Center 4940 Eastern Avenue 21224

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02418

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ERNEST M, MILLS, SR.

2. Date of Death Month: 1 Day: 26 Year: 01

3. Time of Death: 830am

4a. Facility Name *(If not institution, give street and number)*: ST AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 212-07-0592

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 13, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 509 S. Caton Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Local Union #24 IBEU

17. Father's Name *(First, Middle, Last)*: William N. Mills, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha P. Prebie

19a. Informant's Name/Relationship *(Type, Print)*: Ernest M. Mills, Jr. - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3122 Stafford St., Baltimore, Md. 21229

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 1/30/01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Ave. Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — DAYS.

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — YEARS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturet 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ MD.

29c. License number: P-14445

29d. Date signed *(Month, Day, Year)*: 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ST AGNES HEALTHCARE, 900 CATON AVE, BALTIMORE - MD - 21229

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature ▶ for D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME ERNEST M MILLS

10

01-0454-510
B.K.S

ANTHONY MCCOY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony E. McCoy
2. Date of Death Month Day Year: JAN. 27, 2001
3. Time of Death: 0824 AM
4a. Facility Name (If not institution, give street and number): 633 NORTH AISQUITH STREET APT.8-F
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-54-4868
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 290 S. Dallas Ct.
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 11; College (1-4or 5+): 8
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Handyman
16b. Kind of Business/Industry: Self-employed

17. Father's Neme (First, Middle, Last): Alexander McCoy Sr.
18. Mother's Name (First, Middle, Meiden Surneme): Beulah Ellison

19a. Informant's Name/Reletionship (Type, Print): Mr. Alexander McCoy Jr. (Brother)
19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4014 Walrad St. Balto. Md. 21229

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Garrison Forest
Date: 1/5/2001
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funerel Service Licensee: Joseph L. Russ
22. Name end Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)
e. Cirrhosis

Due to (or es a consequence of):
b. Chronic Alcoholism

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

Due to (or es a consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings aveilable prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, etreet, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Ruret Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated. 2 [X] **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Dennis J Chutes
29c. License number: O.C.M.E
29d. Dete signed (Month, Day, Year): JAN. 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutes 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 31 2001
32. Registrar's Signeture: per D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

17/

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02420

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MATTIE LOUISE MOORE

2. Date of Death Month / Day / Year: January 28 2001

3. Time of Death: 7:10 AM

4a. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-90-2052

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 3, 1918

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 319 BIRKWOOD AVENUE

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4TH; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC

16b. Kind of Business/Industry: PRIVATE HOMES

17. Father's Name *(First, Middle, Last)*: WHIT MCLAUGHLIN

18. Mother's Name *(First, Middle, Maiden Surname)*: MAELIZA IRBY

19a. Informant's Name/Relationship *(Type, Print)*: BISHOP DOUGLAS WILLIAMS

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 300 S. PATTERSON PARK AVE. BALTO, MD. 21231

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST VETERANS CEM.

Date: FEB. 02, 2001

20c. Location - City or Town, State: OWINGSMILLS, MD.

21. Signature of Funeral Service Licensee: Calvin B. Scruggs Jr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asystole — Seconds

Due to (or as a consequence of):
b. Myocardial infarction — Six days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD.

29c. License number: AT 2438946

29d. Date signed *(Month, Day, Year)*: January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eskandar Yazaji, MD Dept. of medicine, 201 E. University Pkwy, Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Donna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02421

NGUYEN, HUON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Huon Thi Nguyen
2. Date of Death (Month, Day, Year): JANUARY 27, 2001
3. Time of Death: 7:10 Am
4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-02-4979
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 7, 1909
9. Birthplace *(State or Foreign Country)*: Vietnam

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1799 Severn Hills Lane
10f. Zip Code: 21144
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Minh Van Nguyen
18. Mother's Name *(First, Middle, Maiden Surname)*: Biet Thi Tran

19a. Informant's Name/Relationship *(Type, Print)*: Diem Du - granddaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1799 Severn Hills Lane, Severn, Md. 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery
Date: 2/03/01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Mgt. Marshall
22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge Mem. Pk. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.
29c. License number: D51664
29d. Date signed *(Month, Day, Year)*: JANUARY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR KUMAR AGGARWAL NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02422

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pablo Emilio Osorio-Reyes

2. Date of Death Month / Day / Year: January 28 2001

3. Time of Death: 11:10PM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-88-3821

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 16, 1903

9. Birthplace *(State or Foreign Country)*: Colombia

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2900 Southern Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A./Colombia

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☒ Yes 2 ☐ No *Specify:* Colombian

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Businessman

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Salvador Osorio

18. Mother's Name *(First, Middle, Maiden Surname)*: Gregoria Reyes

19a. Informant's Name/Relationship *(Type, Print)*: Paul E. Osorio-Carmona- Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2900Southern Ave., Baltimore, MD 21214

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Moreland Memorial Park | Date: 2/3/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: William G. Dau

22. Name and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Causa (Final disease or condition resulting in death)

a. Pneumonia — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: congestive heart failure, coronary artery disease, chronic renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E S Fearn, M.D

29c. License number: AT243946-A2

29d. Date signed *(Month, Day, Year)*: January 28, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): E.S. Fearn, UMH Dept. of Medicine, 201 E. Univ. Pkwy., Balto., MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02423

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Anthony Otterbein

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 10:00 am

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-68-5456

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 4, 1958

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4217 Woodlea Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Building

17. Father's Name *(First, Middle, Last)*: Joseph George Otterbein

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Frances Smith

19a. Informant's Name/Relationship *(Type, Print)*: Catherine A. Otterbein-wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4217 Woodlea Ave., Baltimore, MD 21206

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hilltop Service Corporation | Date: 1/31/01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: William G. Dau

22. Name and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Septic shock	1 day
Due to (or as a consequence of): b.	pneumonia- MRSA	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	ARDS	2 weeks
Due to (or as a consequence of): d.	cutaneous T-cell lymphoma	4 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Wilson MD

29c. License number: AT 2438946 A9

29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Wilson 201 East University Parkway Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 12 PER F.H. G791 1-31-01 WR. *Certificate of Death* Reg. No 2001 02424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNEST POINTER
2. Date of Death: Month 01 Day 28 Year 2001
3. Time of Death: 10 35 PM
4e. Facility Name (If not institution, give street and number): BALTIMORE VETERANS ADMINISTRATION
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-56-7994
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 24, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1610 Barclay St.
10f. Zip Code: 21202
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barber
16b. Kind of Business/Industry: Barber Shop

17. Father's Name (First, Middle, Last): James E. Pointer
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Johnson Graham

19a. Informant's Name/Relationship (Type, Print): Jeanette Haskins - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3333 Kentucky Ave. Balto, MD 21213

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 1-29-01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Frederick Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. ASYSTOLE
Due to (or as a consequence of):
b. ENDOCARDITIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: NK Goraya MD
29c. License number: P13377
29d. Date signed (Month, Day, Year): 01/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NAVJIT K. GORAYA 10 N. Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Jeanne S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CAROL POLLACK
2. Date of Death (Month, Day, Year): JANUARY 28TH 2001
3. Time of Death: 12:05 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 235-22-0896
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1924
9. Birthplace (State or Foreign Country): W.V.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 303 E. Cherry Hill Rd.
10f. Zip Code: 21136
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Photojournalist
16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Last): John J. Lough
18. Mother's Name (First, Middle, Maiden Surname): Mabel Dague

19a. Informant's Name/Relationship (Type, Print): Craig R. Piotte
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Sunnyking Dr. Reisterstown, Md. 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: Jan. 31, 2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ J. Scott Pollock
22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ULCERATIVE COLITIS.
PERIPHERAL VASCULAR DISEASE
GANGRENE LEFT LOWER EXTREMITY.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: ▶ Harish MD.
29c. License number: D42723.
29d. Date signed (Month, Day, Year): JANUARY 28TH 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI M HARISH. NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph A Partee
2. Date of Death (Month, Day, Year): Jan 27th 2001
3. Time of Death: 01:25
4a. Facility Name (If not institution, give street and number): Baltimore VA Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-16-6146
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 20 25
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 2902 Woodland Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 2 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electric Technical
16b. Kind of Business/Industry: Bethlehem Steel Corp

17. Father's Name (First, Middle, Last): Levi Partee
18. Mother's Name (First, Middle, Maiden Surname): Hallie Johnson

19a. Informant's Name/Relationship (Type, Print): Dorothy C. Partee-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2902 Woodland Ave, Baltimore Md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 2/1/01
20c. Location - City or Town, State: Pikesville, Md

21. Signature of Funeral Service Licensee: Gary L. Thompson
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD exacerbation
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dungnk Lang MD
29c. License number: P13381
29d. Date signed (Month, Day, Year): Jan 27th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22. South Greene Street Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Rose Robusto
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 10:10 A.M.
4a. Facility Name (If not institution, give street and number): Genesis Heritage Meridian Eldercare Ctr.
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-24-4906
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 26, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1206 Keywood Court
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Walker
18. Mother'a Name (First, Middle, Maiden Surname): Anna Maibohm

19a. Informent's Name/Relationship (Type, Print): Daughter Mrs. Lorraine Williams
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1206 Keywood Court Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Oak Lawn Cemetery | Dete: 2/1/2001
20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. Lisf only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. cerebro vascular Accident — 2 weeks.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Raguerio MD
29c. License number: D 53720
29d. Dete signed (Month, Dey, Year): 01/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Raguerio MD, 2112 Belair Rd #1, Reallston, MD 21047

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

01-0421-510
crn
Jamal Antonio Rogers

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jamal A. Rogers

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 12:35 P.M.

4a. Facility Name (If not institution, give street end number): 1400 Block Cherry Hill Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-02-8552

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 17 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-12-83

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedant

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX

10e. Street and Number: 2336 Nevada Street

10f. Zip Code: 21230

10g. Citizen of What Country: USA

11. Marital Status: XX Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 9th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Never-worked

16b. Kind of Business/Industry: unemployed

17. Father's Name (First, Middle, Last): Walter Rogers

18. Mother's Name (First, Middle, Meiden Sumame): Jacqueline Townes

19a. Informant's Name/Relationship (Type, Print): Jacqueline Townes

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code): 412 Lorraine Avenue Baltimore, Maryland 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Voshell Mem. Gardens

Date: 02-01-2001

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funaral Service Licensaa: Daniel L. Hunter

22. Nama and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditfone** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? X 1 [ ] Yes 2 [ ] No

26. Place of Deeth (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Menner of Deeth: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year): 1-25-01

28b. Time of Injury: 1221p M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Dascribe how Injury occurred: motor bike accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete): 1400 Blk Cherry Hill Rd Baltimore, Md

29a. Certifier (Check only one): 1 [ ] Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Dennis J Cluten

29c. License number: O.C.M.E.

29d. Data signed (Month, Dey, Year): January 26, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Dennis Chuten 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02429

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Chester Ritenour

2. Date of Death — Month: January; Day: 28; Year: 2001

3. Time of Death: 7:15pm

4a. Facility Name *(If not institution, give street end number)*: Mariner Health of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216 24 4667

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 24, 1930

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8494 Roberts Road

10f. Zip Code: 21043

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1947-51

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: Telephone Company

17. Father's Name *(First, Middle, Last)*: Oscar Ritenour

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Cavey

19a. Informent's Name/Reletionship *(Type, Print)*: Kathleen Smith/Daughter

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8494 Roberts Road Ellicott City, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Crest Lawn Memorial Park — Date: 2-2-2001

20c. Location - City or Town, State: Marriottsville, MD

21. Signeture of Funeral Servica Licansee: Sharon A Collins — MD1044 — Hthe

22. Name end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death)
a. ACUTE CEREBROVASCULAR ACCIDENT — 5 minutes

Due to (or es e consequenca of):
b. GENERALIZED ARTERIOSCLEROSIS

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

Due to (or as a consequence of):
c.

Due to (or es e consequenca of):
d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

DEMENTIA

SKIN ULCERS

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: M.D.

29c. License number: D-22609

29d. Date signed *(Month, Day, Yeer)*: January 29, 2001

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print): RUBEN REIDER M.D. 7445 FURNACE BRANCH Rd Glen Burnie MD 21060

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 31 2001

32. Registrar's Signeture: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles W. Ruff
2. Date of Death Month Day Year: JANUARY 28, 2001
3. Time of Death: 15:38
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-28-3760
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01 14 1931
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1604 Timbercrest Drive
10f. Zip Code: 21228
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor
16b. Kind of Business/Industry: Charles F. Ruff, Inc.

17. Father's Name (First, Middle, Last): Charles F. Ruff
18. Mother's Name (First, Middle, Maiden Surname): Charlotte Armstrong

19a. Informant's Name/Relationship (Type, Print): Marilyn Jane Ruff/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1604 Timbercrest Drive, Catonsville, Md. 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National Cem
Date: 02 01 01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc
736 Edmondson Avenue, Balto, Md. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Arteriosclerotic Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Bergeson
29c. License number: D0055849
29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Bergeson St. Agnes Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: P. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RUFF, CHARLES W.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02431

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frederick Robinson

2. Date of Death Month / Day / Year: January 29, 2001

3. Time of Death: 12:00 pm

4a. Facility Name *(If not institution, give street and number)*: 2738 Marbourne Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 228-42-9408

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 22, 1936

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2738 Marbourne Ave.

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Service Tech

16b. Kind of Business/Industry: American Office

17. Father's Name *(First, Middle, Last)*: Thomas Robinson

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Tunstall

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Cleo Robinson (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2738 Marbourne Ave. Balto. Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Union Hope Church Cemetery | Date: 2/3/2001

20c. Location - City or Town, State: Center Cross, Virginia

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C V —

29c. License number: P13416

29d. Date signed *(Month, Day, Year)*: JAN 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHAIM VANEK 22 S. GREENE ST. BALTIMORE 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Penny B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0363-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

GUS SIDIROPOULOS Amend Item#1 per MeoG793 3/28/01 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GUS GEORGE ~~SIDROPOULOS~~ SIDIROPOULOS

2. Date of Death Month Day Year: JANUARY 22, 2001

3. Time of Death: 2:00P.M.

4e. Facility Name (If not institution, give street and number): 146 VILLA CAPRI CIR.

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-16-3693

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 10, 1921

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 146 Villa Capri Circle

10f. Zip Code: 21221

10g. Citizen of What Country: USA

11. Meritel Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '42-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9
College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mechanic

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): George Sidropoulos

18. Mother's Neme (First, Middle, Maiden Surneme): Sophie Filides

19e. Informant's Neme/Relationship (Type, Print): O.C.M.E.

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 111 Penn Street Baltimore, MD 21201

20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece):

Dete:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 1/20/01

28b. Time of Injury: 1300 HR

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject Shot Self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 146 Villa Capri Court Essex Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Theodore M. King MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AGNES M. SIVINSKI
2. Date of Death — Month: JAN Day: 26 Year: 2001
3. Time of Death: 12:45 PM
4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 469-20-9597
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 100 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/11/1900
9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5842 Slate Hill Place
10f. Zip Code: 21704
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Peter Frey
18. Mother's Name (First, Middle, Maiden Surname): Mary Maier

19a. Informant's Name/Relationship (Type, Print): John A. Sivinski/ son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5842 Slate Hill Place Frederick, Maryland 21704

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Calvary Cemetery
Date: 2/2/01
20c. Location - City or Town, Stete: Minneapolis, Minnesota

21. Signature of Funeral Service Licensee: Stan Andrzejewski
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Baltimore, Maryland 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's disease, end stage — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Osteoarthritis, Right tibia, fibular fracture
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B Lee MD
29c. License number: D42544
29d. Date signed (Month, Day, Year): JAN 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin S. Lee, M.D., 700 Geipe Rd, #204, Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Sivinski, Agnes

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02434

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Myrtle R. Sponaugle

2. Date of Death (Month, Day, Year): Jan. 26, 2001

3. Time of Death: 8:15 PM

4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-36-4007

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 25, 1907

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 408 Orchard Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Warner

18. Mother's Name *(First, Middle, Maiden Surname)*: Ina Waybright

19a. Informant's Name/Relationship *(Type, Print)*: Shirley Heffner - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7840 Camp Road, Pasadena, Md. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park | Date: 1/30/01

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Richard M. Peters

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Mead. M. P., Inc. 7250 Washington Blvd., Elkridge, Md. 21075

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 10 days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] M.D.

29c. License number: D55506

29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FEREREN 3721 Potee Street Baltimore Md. 21225

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jasper Wallace Stevenson
2. Date of Death: Month January Day 26 Year 2001
3. Time of Death: 6:15PM
4a. Facility Name (If not institution, give street and number): 1270 Walker Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-22-4286
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 7 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1270 Walker Ave.
10f. Zip Code: 21239
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Repair & Service
16b. Kind of Business/Industry: Bell Atlantic

17. Father's Name (First, Middle, Last): Jasper King Stevenson
18. Mother's Name (First, Middle, Maiden Surname): Edna Shultheis

19a. Informant's Name/Relationship (Type, Print): Mrs. Rita Jean Stevenson/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1270 Walker Ave. Baltimore, Md. 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens | Date: 1-31-01
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: ▶ Kit J Faust
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bronchogenic Carcinoma	5 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen Selinger
29c. License number: 26717
29d. Date signed (Month, Day, Year): 1/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Selinger, Md. 9000 Franklin Square Drive Baltimore, Md. 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: ▶ G. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02436

Szczerbicki, Albert

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert J. Szczerbicki

2. Data of Death Month / Day / Year: January 27 2001

3. Time of Death: 153pm

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-10-1606

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Jan. 14, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1941 Ormand Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Service

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Frank Szczerbicki

18. Mother's Name *(First, Middle, Maiden Surname)*: Josephine Kruszynska

19a. Informant's Name/Relationship *(Type, Print)*: Mr. William Siegmund (Step) (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1941 Ormand Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 1/30/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Duda-Ruck Funeral Home of Dundalk, Inc.

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured Abdominal Aortic Aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Yaw Bole MD

29c. License number: MD 192732

29d. Date signed *(Month, Day, Year)*: 1/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Lance Barker 9000 Franklin Square Drive Baltimore MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Geneva B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert E. Smith, Sr.

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 12:15 AM

4a. Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-12-8758

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 21,1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1207 Paul Martin Drive

10f. Zip Code: 21040

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumbing Inspector

16b. Kind of Business/Industry: City of Baltimore

17. Father's Name (First, Middle, Last): Russell Smith

18. Mother's Name (First, Middle, Maiden Surname): Katheryn R. Gallatin

19a. Informent's Neme/Reletionship (Type, Pnint): Albert E. Smith, Jr. - Son

19b. Mailing Address (Street end Number or Rurat Route Number, City or Town, State, Zip Code): 2741 Singer Woods Drive Abingdon, MD 21009

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Pleca of Disposition (Name of cemetery, cremetory or other place): Gardens of Faith

Date: 1/30/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funerel Service Licensee: Paul L. Hartsock Jr.

22. Name end Address of Fecility: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. END STAGE CARDIAC DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [illegible]

29c. License number: D43725

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Brenda G Sparks

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

JANUARY 27, 2001 12:15 a.m.

ALBERT SMITH

01-0468-005
JERRY R. SWAN
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,27,28a-f per M.E. G792 020701 SS

Certificate of Death

Reg. No. 2001 02438

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Jerry Ray Swan
2. Data of Deeth: Month JANUARY Dey 28 Yeer 2001
3. Time of Death: 8:34 A
4a Feclity Nama *(If not institution, give street and number)*: 6923 RIDGEWAY RD.
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-56-8911
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 21,1951
9. Birthpleca *(Steta or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Insida City Limits: 1☐Yes 2☒No
10e. Street and Number: 6923 Ridgeway Road
10f. Zip Code: 21222
10g. Citizen of Whet Country?: United States
11. Meritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Giva Yaer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: White
15. Decedent's Eaucetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 Years; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work dona dunng most of working life. DO NOT use retired)*: Automobile Parts Delivery
16b. Kind of Business/Industry: Automobile Parts
17. Father's Name *(First, Middle, Last)*: Donald Ray Swan
18. Mother's Name *(First, Middle, Meiden Surneme)*: Betty Jo Pennington
19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Susan J. Swan (Wife)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6923 Ridgeway Road Dundalk, Maryland 21222
20a. Mathod of Disposition: 1☐Buriel 2☒Cremetion 3☐Ramoval from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Hilltop Service Corp. Dete: Jan. 21,2001
20c. Location - City or Town, Stete: Towson, Maryland
21. Signeture of Funerel Service Licensee
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha daath. Do not entar tha mode of dying, such es cerdiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. — Approximete Interval Between Onset and Death

Immediata Cause (Finel diseese or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as e consequence of):

Sequentially tist conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseasa or injury thet Initieted events resulting in death) Last

b.

Dua to (or as a consequenca of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Dtd tobacco use contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Wes cese refarred to medical examiner? 1☒Yes 2☐No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* SCENE

27. Menner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☒Could not be determined

28a. Dete of Injury *(Month, Day Year)*: found 1-28-01
28b. Time of Injury: found 8:24 Ma
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: SUBJECT INGESTED DRUGS
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: FOUND AT HOME
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: 6923 Ridgeway Road Balt., MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E
29d. Data signed *(Month, Day, Year)*: JANUARY 29,2001

30. Neme and address of person who completed ceuse of death-(Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signeture: Geneva G Spats

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02439

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen M. Schwatka

2. Date of Death: Month January, Day 24, Year 2001

3. Time of Death: 7:46 Pm

4a. Facility Name *(If not institution, give street and number)*: Golden Age Guest Home, Inc.

4b. City, Town, or Location of Death: Windfield

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-34-9004

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10/11/1905

9. Birthplaca *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. Stete: MD

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 201 Watersville Road

10f. Zip Coda: 21771

10g. Citizan of What Country?: USA

11. Maritat Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Nama *(First, Middla, Last)*: John J. Miller

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Mary McNamara

19a. Informant's Name/Ralationship *(Type, Print)*: Suzanne Mead Daughter

19b. Mailing Address *(Straet and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 707 Horpel Drive Mt. Airy, MD 21771

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of camatary, cramatory or other place)*: Balto-Wash. Crematory

Data: 01/26/01

20c. Location - City or Town, Stata: Laurel, Maryland

21. Signature of Funaral Service Licensee: Ted Allen

22. Name and Address of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onsat and Death

Immediata Causa (Final disease or condition rasulting in death)

a. PRIMARY DEGENERATIVE DEMENTIA — >5 YRS

Dua to (or as a consequance of):

Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☑ No

25. Was casa refarrad to medical examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Naturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowladga, death occurred at tha time, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examinetion end/or invastigation, in my opinion, daath occurrad st tha tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: Patrick Turners

29c. Licansa number: D20806

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): PATRICK TURNER MD 1000 LIBERTY RD ELDERSBURG, MD 21784

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jack Shapiro
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 10:15 AM
4a. Facility Name (If not institution, give street and number): 1108 Anglesea Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-01-2965
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 24 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No — X
10e. Street and Number: 1108 Anglesea Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S. of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Export Specialist
16b. Kind of Business/Industry: Exporting

17. Father's Name (First, Middle, Last): Moritz Shapiro
18. Mother's Name (First, Middle, Maiden Surname): Anna Rosenberg

19a. Informant's Name/Relationship (Type, Print): Jeanette Owens (Stepdaughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Maxwell Rd. Balto., Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Oak Lawn
Date: February 2,2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mark A Chojnacki
22. Name and Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hepatocellular Carcinoma	3 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dana S Simpler
29c. License number: D35170
29d. Date signed (Month, Day, Year): 11/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANA S. SIMPLER MD 808-810 S. CONKLING ST. BALTO. MD 21224

State Registrar

31. Date filed (Month, Day, Year): JAN 3 1 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0364-510
LRB
JOSEPH SCHICK

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02441

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph George Schick, Jr.
2. Data of Death — Month: January Day: 22 Year: 2001
3. Time of Death: 1:18 P.M.
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-8605
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/09/1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1900 Eastfield Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Merital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Giva Yeer or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manufacturing Worker
16b. Kind of Business/Industry: Pemco

17. Father's Nema (First, Middle, Last): Joseph George Schick, Sr.
18. Mothar's Name (First, Middle, Meiden Surname): Eunice Olivia Baynes

19a. Informant's Name/Relationship (Type, Print): Elizabeth Schick Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1900 Eastfield Road, Dundalk MD 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park
Date: 1/25/01
20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: [signature]
22. Nama end Address of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Road, Dundalk, MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such es cerdiac or respiratory arrest, shock, or heart fasure. List only one cause on each line. — Approximate Interval Between Onsat and Daath

Immediate Cause (Final diseasa or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due fo (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Inspection 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 8 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated.
29b. Signature and title of certifier: [signature] Theodore King M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 23, 2001
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie Lee Tate
2. Date of Death Month / Day / Year: 1 / 26 / 2001
3. Time of Death: 8:25p. M
4a. Facility Name (If not institution, give street and number): 6630 Ebete Drive
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 244-42-0823
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-9-1929
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6630 Ebete Drive Apt 103
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: Blach
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Chief
16b. Kind of Business/Industry: Rosewood Center
17. Father's Name (First, Middle, Last): John Tate
18. Mother's Name (First, Middle, Maiden Surname): Hattie
19a. Informant's Name/Relationship (Type, Print): Rev. Yvonne C. Tate - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6630 Ebete Dr Apt 103 Balto, md 21215
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Mt Zion Cem
Date: 1-31-2001
20c. Location - City or Town, State: Lansdown, md
21. Signature of Funeral Service Licensee: Barry N. Krumpeck
22. Name and Address of Facility: Mayer F.H. West 4300 Wabash Avenue Balto, md 21215

Physician /Medical Examiner

24a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute myocardial infarction massive

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
b. Coronary artery disease

Due to (or as a consequence of):
c. Hypertensive atherosclerosis cardio

Due to (or as a consequence of):
d. vascular disease.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Insulin dependent Diabetes Mellitus.
Alzheimer's disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: David J. Penn MD
29c. License number: D29928
29d. Date signed (Month, Day, Year): 1/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Penn MD 1838 Green Tree Rd Suite 300 Pikesville MD 21208

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Geneva G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02443

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GREGORY TOMS

2. Data of Daath — Month: JANUARY Day: 23, Yaar: 2001

3. Time of Death: 3:40 PM

4a Facility Name *(If not institution, give street and number)*: Millenium of Marley Neck

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-74-0927

6. Sax: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Yaar)*: Mar 18, 1951

9. Birthplaca *(State or Foraign Country)*: unk

Usual Rasidance of Decedent

10a. Stata: unk

10b. County: unk

10c. City, Town or Location: unk

10d. Insida City Limits: unk — 1 [ ] Yas 2 [ ] No

10e. Street and Number: unk

10f. Zip Code: unk

10g. Citizan of Whet Country?: USA

11. Marital Status: unk — 1 [ ] Nevar Marriad 2 [ ] Marriad 3 [ ] Widowad 4 [ ] Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [ ] No unk — If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Raca - Amarican Indian, Black, White, atc. *Specify:* black

15. Decedant's Education *(Specify only highast grade compiatad)*

Elamentery/Secondary (0-12): unk

Collega (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: unk

16b. Kind of Businass/Industry: unk

17. Fathar's Nama *(First, Middla, Last)*: unk

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: unk

19a. Informant's Neme/Reletionship *(Type, Print)*: Millenium of Marley Neck

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7575 E. Howard Road Glen Burnie, MD 21060

20a. Mathod of Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [X] Othar *(Specify)* in state

20b. Placa of Disposition *(Nama of camatary, crametory or othar placa)*

Date

20c. Location - City or Town, Stata

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Nama and Addrass of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Cause (Final disaasa or condition rasulting in daath) a. AIDs — months

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last

b.

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referrad to medical examinar? 1 [ ] Yas 2 [✓] No

26. Placa of Daath *(Check only one)*

Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA

Othar: 4 [✓] Nursing Home 5 [ ] Residanca 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [✓] **Certifying Phyaician:** To tha bast of *my* knowledga, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at tha time, date and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of certifier: MD

29c. License number: D-50725

29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Jennifer Riedinger 479 Jumpers Hole Severna Park MD 21146

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 31 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Tyler
2. Date of Death: Month 01 Day 22 Year 2001
3. Time of Death: 10:32 PM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 245-90-6040
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22 1955
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7844 Saint Claire Lane
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Indian

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Nama (First, Middle, Last): Alfred Miller
18. Mothar's Name (First, Middle, Maiden Surneme): Arrie Pevia

19a. Informant's Name/Relationship (Type, Print): Hector Candelario Friend
19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code): 7844 Saint Claire Lane Baltimore, MD 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Balto-Wash. Crematory
Date: 01/27/01
20c. Location - City or Town, Stata: Laurel, MD

21. Signature of Funaral Servica Licensee: ▶ [signature]
22. Nama and Address of Facility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD Baltimore, MD 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina. — Approximata Interval Between Onset and Death

Immediata Cause (Final disaase or condition resulting in daath): a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.: Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was cese referred to medicel examinar? 1☐ Yes 2☒ No
26. Place of Daath (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladge, daath occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ [signature] MD-Resident Physician
29c. Licansa number: P13355
29d. Data signad (Month, Day, Year): 01/22/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Michael Akom MD, Internal Medicine. 22. S. Greene St. Baltimore, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Wright
2. Date of Death: Month January Day 24 Year 2001
3. Time of Death: 10:45Am.
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 144-38-5781
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-19-46
9. Birthplace (State or Foreign Country): Newark N.J.

Usual Residence of Decedent

10a. State: Md
10b. County: BALTO.
10c. City, Town or Location: TURNER STATION
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 627 AVALON Rd.
10f. Zip Code: 21222
10g. Citizen of Whet Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Black, White, etc. Specify: BLACK.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CATERER
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): JAMES Wright
18. Mother's Name (First, Middle, Maiden Surname): Josephine Eley

19a. Informant's Name/Relationship (Type, Print): micheal Shields
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 627 AVALON Rd BALTO. Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): MT CARMEL
Date: 2-03-01
20c. Location - City or Town, State: BALTO. Md.

21. Signature of Funeral Service Licensee: Wesley Chavis
22. Name and Address of Facility: CHAVIS F.H. 2007 EASTERN AVE BALTO. MD. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final disease or condition resulting in death):
a. SEPTICEMIA
Due to (or as a consequence of):
b. DISSEMINATED INTRAVASCULAR COAGULOPATHY
Due to (or as a consequence of):
c. COLON CANCER
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): January 24 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Aspen Onesunju. 301 Hospital Drive, Glen Burnie. MD. 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Barbara G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VIRGINIA WRIGHT

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY WATSON
2. Date of Death (Month, Day, Year): JANUARY 26 2001
3. Time of Death: 7:20 AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 180-30-9343
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-16-1937
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD. 10b. County: n/a 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1222 Mapleleaf Ct. 10f. Zip Code: 21202 10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker
16b. Kind of Business/Industry: Baltimore City Health Dept.

17. Father's Name (First, Middle, Last): Douglas Harris
18. Mother's Name (First, Middle, Maiden Surname): Lillian Creasy

19a. Informant's Name/Relationship (Type, Print): Diane Harris-Randall (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 Maple Leaf Ct. Balto. MD. 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Date: 1/30/01
20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Nathaniel Butts
22. Name and Address of Facility: Butts Funeral Home 1129 N. Caroline St. Balto. MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCULAR ACCIDENT	15 DAYS
Due to (or as a consequence of):	b. ATRIAL FIBRILATION	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ASPIRATION PNEUMONIA	10 DAYS
Due to (or as a consequence of):	d. SEPSIS	5 DAYS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION, RENAL ARTERY STENOSIS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kerri Cavanaugh
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KERRI L. CAVANAUGH 600 N. WOLFE STREET JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cornelia Wharton

2. Date of Death: Month 01 Day 26 Year 01

3. Time of Death: 10:30pm

4a. Facility Name (If not institution, give street and number): Genesis Long Green Center

4b. City, Town or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 212-18-2301

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/9/03

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 115 East Melrose Avenue

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Social Security Administration

17. Father's Name (First, Middle, Last): Benjamin Douglas

18. Mother's Name (First, Middle, Maiden Surname): Lillian May Hedgeman Mason

19e. Informant's Name/Relationship (Type, Print): Ann Marie Woods-cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3661 Wabash Ave. Balto. MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk. Cem.

Date: 01/31

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Herbert E. Nutter

22. Name and Address of Facility: Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonitis — 1-2 weeks

Due to (or as a consequence of):

b. Multi-infarct Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending

29c. License number: D17118

29d. Date signed (Month, Day, Year): JAN 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 115 E. Melrose Ave 21212

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT WILLIAM WALSH

2. Date of Death (Month Day Year): January 29, 2001

3. Time of Death: 8:00 AM

4a. Facility Name (If not institution, give street and number): 1210 Carrollton Lane

4b. City, Town, or Location of Death: Ocean Pines

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 137-28-9226

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 5, 1935

9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedant

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: Ocean Pines

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 1210 Carrollton Lane

10f. Zip Code: 12811

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Nevar Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elamentary/Secondary (0-12): 12

Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Agent

16b. Kind of Business/Industry: Bershire Life Insurance

17. Father's Nama (First, Middle, Last): John J. Walsh

18. Mothar's Neme (First, Middle, Maiden Sumeme): Anna J. Walters

19a. Informant's Name/Ralationship (Type, Print): Mrs. Helen V. Walsh/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1210 Carrollton Lane Ocean Pines, Md. 21811

20a. Mathod of Disposition: 1 [ ] Burial 2 [ ] Cramation 3 [X] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Pine Hill Cemetery

Date: 2/2/01

20c. Location - City or Town, State: Middletown, N.Y.

21. Signature of Funaral Sarvice Licensee

22. Nema and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23e. Part1. Enter tha disaasa, or complications that causad tha death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart feilura. List only ona causa on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Final diseese or condition rasulting in death)

a. Idiopathic pulmonary f.brosis — 2 yrs

Dua to (or as a consequence of):

Sequentially list conditions, if any, laeding to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes casa rafarred to medical axaminar? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Dey Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and piece, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: physician

29c. License number: H44283

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durkin 9733 Healthway Drive Berlin, MD

State Registrar

31. Data filed (Month, Dey, Year): JAN 31 2001

32. Registrar's Signature: Brian B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#20b&c PER F.H. G791 1-31-2001 JAB

Certificate of Death

Reg. No 2001 02449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie Tucker WYNN

2. Date of Death: Month 01 Day 28 Year 2001

3. Time of Death: 2:50 AM

4a. Facility Name (If not institution, give street and number): HAMMond's Lane Nursing Center

4b. City, Town, or Location of Death: Brooklyn Park

4c. County of Death: AACO

Funeral Director

5. Social Security Number: 215-22-0911

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 07 1921

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: AACO

10c. City, Town or Location: GLENBURNIE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6555 BOOKER RD.

10f. Zip Code: 21060

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CATERER

16b. Kind of Business/Industry: Glenn L. MARTIN

17. Father's Name (First, Middle, Last): MATTHEW TUCKER

18. Mother's Name (First, Middle, Maiden Surname): NANNIE DRUMMON

19a. Informant's Name/Relationship (Type, Print): JAMES WYNN /HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6555 BOOKER RD., GLENBURNIE, MD. 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~KING MEMORIAL PARK~~ CROWNSVILLE VET. CEM.

Date: 2/1/2001

20c. Location - City or Town, State: CROWNSVILLE, MD. ~~BALTO., MD.~~

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Metastatic Colon Cancer — 2 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: MD

29c. License number: D53462

29d. Date signed (Month, Day, Year): 1/29/01

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Jude Munoses 7845 Oakwood Road Glen Bornie, MD 21061

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Edward Woodland
2. Date of Death: Month JANUARY Day 28 Year 01
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-20-6160
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 28, 1926
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1430 Pennsylvania Avenue
10f. Zip Code: 21217
10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 45-48
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Longshoreman

17. Father's Name (First, Middle, Last): William Woodland
18. Mother's Name (First, Middle, Maiden Surname): Lillian Young

19a. Informant's Name/Relationship (Type, Print): Mr. Charles Page-Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4400 Belle Avenue, Baltimore, MD 21217

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forrest V. A.
Date: Feb 2 2001
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Calvin I. Williams
22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. ASCVD - Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):
b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
COPD - Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Pat Weber MD
29c. License number: D31704
29d. Date signed (Month, Day, Year): JANUARY 28, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): Patricia Weber, M.D. 9 Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: ▶ per L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

THOMAS WOODLAND 217-20-6160

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02451

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary A. Young

2. Date of Death Month Day Year: January 28, 2001

3. Time of Death: 12:35 PM

4e Facility Name *(If not institution, give street end number)*: Manor Care Nursing Home-Rossville

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-22-6752

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 27, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 51 Olde Forge Lane

10f. Zip Code: 21236

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 yr's / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Vincenzo DelGiudice

18. Mother's Name *(First, Middle, Maiden Surname)*: Marianna Damiano

19a. Informent's Name/Relationship *(Type, Print)*: Mrs. Yolanda Udovich-Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2013 Kilbourne Road Baltimore, Maryland 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Holy Redeemer

Data: 1/31/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Christina L. Hilton ▶ Christina L. Hilton

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — 6 Mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ M. Rhanama

29c. License number: D45425

29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Rhanama 8100 Harford Rd. Baltimore, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Macabee N. Young

2. Date of Death (Month, Day, Year): JAN. 25, 2001

3. Time of Death: 1:00 A.M.

4a. Facility Name (If not institution, give street and number): Blue Point Nursing & Rehab

4b. City, Town or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-12-7655

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 2, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3725 Manchester

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard

16b. Kind of Business/Industry: Security

17. Father's Name (First, Middle, Last): Rev. Cornelius W. Young

18. Mother's Name (First, Middle, Maiden Surname): Gladys Wiley

19a. Informant's Name/Relationship (Type, Print): Irene M. Young - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3725 Manchester Balto., MD. 21215

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 2-5-01

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Gary D. Myers

22. Name and Address of Facility: Gary Ermarth Funeral Home P.A. 270 Fredhilton Pass Balto, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	1 WK
Due to (or as a consequence of): b.	Cerebrovascular accident	2 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Hypertension	4 yrs
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amatun N Naeem MD

29c. License number: D 15503

29d. Date signed (Month, Day, Year): Jan, 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMATUN N NAEEM, 501 Dolphin st, Balto MD 21217

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02453

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NORMA LEE ANDREWS
2. Date of Death Month / Day / Year: Jan. 17, 2001
3. Time of Death: 1803
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 218-20-8299
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 20 1927
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 29116 Bell Lane
10f. Zip Code: 21601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: sitter
16b. Kind of Business/Industry: home health

17. Father's Name *(First, Middle, Last)*: Ray Whitmore Dean
18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Elizabeth Warfield

19a. Informant's Name/Relationship *(Type, Print)*: Charles Michael Andrews-son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29116 Bell Lane, Easton MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Salisbury Crematory
Date: 1-19-01
20c. Location - City or Town, State: Salisbury Md.

21. Signature of Funeral Service Licensee: ▶ Kenneth R Thomas Jr
22. Name and Address of Facility: Thomas Funeral Home PA
700 Locust St. Cambridge MD 21613

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Tachycardia Arrest — immediate

Due to (or as a consequence of):
b. Hypotension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Metabolic Acidosis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Noel Hunte
29c. License number: D0055225
29d. Date signed *(Month, Day, Year)*: 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Noel Hunte, 219 S. Washington St. Easton MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Norma Andrews
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02454

Joseph F. Chapman

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Joseph F. Chapman
2. Date of Death (Month, Day, Year): Jan. 18, 2001
3. Time of Death: 9:40AM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles
5. Social Security Number: 218-07-7136
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Febuary 14, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 14788 Bassford Rd
10f. Zip Code: 20601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943 1943-
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Grounds Keeper
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): John F. Chapman
18. Mother's Name (First, Middle, Maiden Surname): Irma Yates

19a. Informant's Name/Relationship (Type, Print): Doris Myles/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9425 Lawndale St. Bel Alton, Maryland 20611

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): St. Marys Bryantown
Date: 1/24/01
20c. Location - City or Town, State: Bryantown MD

21. Signature of Funeral Service Licensee: Floyd
22. Name and Address of Facility: M191 Adams Funeral Home P.A. Aquasco MD 20608

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Edema
Due to (or as a consequence of):
b. Renal Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Septic Shock
Due to (or as a consequence of):
d. perforation of cecum

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
peritonitis Appendicitis
Chronic obstructive pulmonary Disease
Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Song M.D.
29c. License number: D37174
29d. Date signed (Month, Day, Year): 1/18/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Song C. Chon, M.D. Cenna Medical Ctr. 7C Post Office Rd. Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION ELIZABETH WOOD GRAY

2. Date of Death (Month, Day, Year): January 19 2001

3. Time of Death: 9:55PM

4a. Facility Name (If not institution, give street and number): Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 213-38-0346

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 15, 1942

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: LA PLATA

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1006 WILTSHIRE DRIVE

10f. Zip Code: 20646

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE

16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): HARRY WOOD

18. Mother's Neme (First, Middle, Maiden Surneme): AUDREY GENEVA MARSHALL HAGENS

19a. Informant's Name/Reletionship (Type, Pnnt): JOHN EDGAR GRAY, SR. / HUSBAND

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1006 WILTSHIRE DRIVE, LA PLATA, MARYLAND 20646

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): ST. PAUL'S CHURCH CEM.

Date: 1/24/01

20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Breast cancer	3yrs
Due to (or as a consequence of): b.	pneumonia	3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Lung metastasis	9 month
Due to (or as a consequence of): d.	Respiratory failure	2 week

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Diabetes mellitus.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or Investigetion, In my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Pritchett M.D.

29c. License number: D-0008370

29d. Date signed (Month, Day, Year): 1/19/01

30. Name end address ot person who completed cause of death (Item 23e) (Type, Print): Paul E. Pritchett, M.D. 118 LaGrange Ave., P.O. Box1317 LaPlata, Maryland 20646

State Registrar

31. Date filed (Month, Dey, Year): JAN 22 2001

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gray Marian

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT ADAMS HICKS JR.

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 1515

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-26-5588

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-25-31

9. Birthplace (State or Foreign Country): TENN.

Usual Residence of Decedent

10a. State: MD. | 10b. County: WICOMICO | 10c. City, Town or Location: PARSONBURG | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 7475 RACHEL LANE | 10f. Zip Code: 21849 | 10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LUMBER JACK

16b. Kind of Business/Industry: J.V. WELLS

17. Father's Name (First, Middle, Last): ROBERT ADAMS HICKS SR.

18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH WILLARD HICKS

19a. Informant's Name/Reletionship (Type, Print): LISA ROWER - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7475 RACHEL LANE, PARSONBURG, MD. 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SPRINGHILL CEMETARY | Date: 1/19/2001

20c. Location - City or Town, State: HEBRON, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: BENNIE SMITH F/H 917 W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Athero sclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32014

29d. Date signed (Month, Day, Year): 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA 106 WILLARD ST 504 B SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Robert A. Hicks, Jr. 215265588

DQ 1-8-01

VOID

CERTIFICATE #

2001-02457

SEE

CERTIFICATE #

00-43607

VOID

CERTIFICATE #

2001-2458

SEE

CERTIFICATE #

00-43606

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02459

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EMILY MARIE LENNON

2. Date of Death Month / Day / Year: January 19, 2001

3. Time of Death: 1:00 PM

4a. Facility Name *(If not institution, give street and number)*: 8017 Holly Avenue

4b. City, Town, or Location of Death: Waldorf

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 094-34-2185

6. Sex: 1☐ M 2☐ F XXX

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1942

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8017 Holly Avenue

10f. Zip Code: 20601

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Statistician

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: Robert Schmidgall

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Shaming

19a. Informant's Name/Relationship *(Type, Print)*: Edward James Lennon - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8017 Holly Avenue, Waldorf, MD 20601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens

Date: 1-23-01

20c. Location - City or Town, State: Waldorf, MD 20601

21. Signature of Funeral Service Licensee: Mark G. Brohawn

Mark G. Brohawn M00053

22. Name and Address of Facility: Huntt Funeral Home, P. O. Box 156, Waldorf, MD 20604

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No XXX

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence XX 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural XXX 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* XXX

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Date signed *(Month, Day, Year)*: 1-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02460

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HENRIETTA H. MCADAMS
2. Date of Death Month Day Year: JANUARY 14, 2001
3. Time of Death: 12:30 AM

4a. Facility Name *(If not institution, give street and number)*: ATRIA ASSISTED LIVING
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 578-14-3904
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 3, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 1110 Healthway Drive
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Professional Girl Scout
16b. Kind of Business/Industry: Girl Scout

17. Father's Name *(First, Middle, Last)*: Julius A. Hobson
18. Mother's Name *(First, Middle, Maiden Surname)*: Lelia W. Haskins

19a. Informant's Name/Relationship *(Type, Print)*: Mary L. Townshend / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 508 South Park Dr., Salisbury, MD 21804

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Salisbury Crematory
Date: 1/16/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: ▶ Kate R Dewey OFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Living Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D28369
29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Bocchiola, MD 1209 Coastal Highway Fenwick Island, DE 19944

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: ▶ Denise G. Sparks

DHMH 16 Rev 6/95

3DQ +2

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNICE JEWEL MURPHY
2. Date of Death: Month January Day 14 Year 2001
3. Time of Death: 16:00 Hrs
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-36-8449
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 10 1921
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1077 Largo Road
10f. Zip Code: 20772
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Yeager Gibson
18. Mother's Name (First, Middle, Maiden Surneme): Mary Johnson Gibson

19a. Informant's Neme/Relationship (Type, Print): Wayne Garofolo (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 12616 Kern Wood Lane Bowie, Maryland 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Maryland Veterans Cem.
Date: 1-22-01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John A. Eberwein M00173
22. Name and Address of Facility: Eberwein Funeral Service, 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Post obstractive pneumonia
Due to (or as e consequence of):
b. Small cell lung cancer
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditfone** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Charles W. Chelya MD
29c. License number: D 41816
29d. Date signed (Month, Day, Year): 1/14/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles W. Chelya MD. Anne Arundel Medical Center 64 Franklin St. Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02462

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Fumilayo Oseni

2. Date of Death Month Day Year: January 24, 2001

3. Time of Death: 9:55 P.M.

4a Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216 29 1691

8. Sex: 1☐ M 2☒ F XX

7. Age *(In yrs. last birthday)*: 11 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 14,1990

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 5909 Plata Street

10f. Zip Code: 20735

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☐ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 5th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: Elementary

17. Father's Name *(First, Middle, Last)*: Morgan Eichie

18. Mother's Neme *(First, Middle, Maiden Surname)*: Ola Abayomi

19a. Informent's Neme/Reletionship *(Type, Print)*: Morgan Eichie (FATHER)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5909 Plata Street, Clinton, Maryland 20735

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removel from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Resurrection Cemetery

Date: Jan 27, 2001

20c. Location - City or Town, Stete: Clinton, Maryland

21. Signature of Funeral Service Licensaa: Kelly R. Pitts

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Cardiac arrhythmia — 15 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last

b. Coarctation of aorta, status post surgery — 11 years

Due to (or as e consequence of):

c. Subaortic stenosis, status post surgery — 11 years

Due to (or es e consequence of):

d. Aortic stenosis and regurgitation — 11 years

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☒ No XX 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas XX 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminar? XX Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signetura and title of certifier: Roger N. Ruckman M.D.

29c. Licanse number: D0024537

29d. Data signed *(Month, Day, Year)*: 01/25/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Roger N. Ruckman, M.D. 111 Michigan Ave. N.W. Washington DC 20010

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signeture: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02463

256-32-7664

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maybell Padilla

2. Date of Death: Month January Day 12, Year 2001

3. Time of Death: 2147

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 256-32-7664

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 11, 1909

9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 503 Viewfield Dr.

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: various

17. Father's Name (First, Middle, Last): Tim McCloud

18. Mother's Name (First, Middle, Maiden Surname): Maggie Reed

19a. Informant's Name/Reletionship (Type, Print): Rev. Rosie Edwards/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 Viewfield Dr., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Green Acres Memorial Park

Date: 1/18/2001

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Subdural hemorrhage — hours

Due to (or as a consequence of):

b. Metastatic Ca — months.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, snd due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D29105

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Chrisjon Huddleston MD 106 Milford St. Salisbury MD. 21801

State Registrar

31. Date filed (Month, Dey, Year): JAN 17 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

256-32-7664

Mae Padilla

5 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARBARA JEAN HART POSEY
2. Date of Death (Month, Day, Year): JANUARY 18, 2001
3. Time of Death: 10:44 PM
4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 219-54-9256
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 30, 1950
9. Birthplace (State or Foreign Country): WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: MARBURY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3075 REEDER PLACE
10f. Zip Code: 20658
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): ROBERT J. HART
18. Mother's Name (First, Middle, Maiden Surname): HESTER E. SAVOY WASHINGTON

19a. Informant's Name/Relationship (Type, Print): PORTIA POSEY / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 174 MARBURY, MARYLAND 20658

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): OAK GROVE BAPTIST CHURCH
Date: 1/22/01
20c. Location - City or Town, State: GRAYTON, MARYLAND

21. Signature of Funeral Service Licensee: LYDIA C. THORNTON JOHNSON M00583
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Dilated Cardiomyopathy
Due to (or as a consequence of):
b. Cardiac arrhythmia
Due to (or as a consequence of):
c. Myocardial Infarction
Due to (or as a consequence of):
d. Mitral Regurgitation with Mitral Valve Repair

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Rosario Fernandez
29c. License number: D19518
29d. Date signed (Month, Day, Year): 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4275 HAWTHORNE RD. INDIAN HEAD, MARYLAND 20640

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02465

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD CARL REED

2. Date of Death Month Day Year: JAN. 20, 2001

3. Time of Death: 12:06AM

4a. Facility Name *(If not institution, give street and number)*: FT. WASHINGTON HOSPITAL CENTER

4b. City, Town, or Location of Death: FT. WASHINGTON

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 478-16-3218

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT. 16, 1918

9. Birthplace *(State or Foreign Country)*: IOWA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: ACCOKEEK

10d. Inside City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Number: 15100 EAST AUBURN ROAD

10f. Zip Code: 20607

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1 ☒ Yas 2 ☐ No If Yes, Give Year or Dates: 1942-1946

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 8

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: PATENT ATTORNEY

16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name *(First, Middle, Last)*: CARL W. REED

18. Mother's Name *(First, Middla, Maiden Surname)*: ALICE M. SWENSON

19a. Informent's Neme/Relationship *(Type, Print)*: MRS. PHYLLIS C. REED - WIFE

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 15100 EAST AUBURN ROAD, ACCOKEEK, MD 20607

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or othar placa)*: CHRIST CHURCH CEMETERY, Date: JANUARY 23, 2001

20c. Location - City or Town, State: ACCOKEEK, MD

21. Signature of Funeral Service Licensee: MGB Mark G Brohawn

MARK G. BROHAWN M00053

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only *one* cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaasa or condition resulting in death) a. Malignant Lymphoma — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Atherosclerosis, prostate cancer

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performad? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier

29c. License number: D19431

29d. Date signed *(Month, Day, Year)*: 1/20/01

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): Frank M. Ryan MD 11701 Livingston Rd #203 Ft. Washington MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN WILBUR TRADER, JR.

2. Date of Death Month: 1 Day: 14 Year: 01

3. Time of Death: 1215

4a. Facility Name (If not institution, give street and number): 220 S. Washington St.

4b. City, Town, or Location of Death: Snow Hill

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 214-36-5465

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/15/1938

9. Birthplace (State or Foreign Country): Dover, DE

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 220 S. Washington St.

10f. Zip Code: 21863

10g. Citizen of What Country? U.S.A.

11. Meritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): John W. Trader, SR.

18. Mother's Name (First, Middle, Meiden Surname): Lila Trader

19a. Intormant's Name/Relationship (Type, Print): Kelly T. Lord/ Daughter

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 313 Holt St. Federalsburg, MD 21632

20a. Method ot Disposition: 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place ot Disposition (Neme of cemetery, cremetory or other piece): Salisbury Crematory

Date: 1/16/01

20c. Location - City or Town, State: Salisbury, MD

21. Signeture of Funeral Service Licensee: [signature]

22. Name and Address of Fecility: Lewis N. Watson Funeral Home 1618 West Rd. Salisbury, MD 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heert teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

tmmediate Ceuse (Finel disease or condition resulting in deeth)

a. CIRRHOSIS — FEW YEARS

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CHRONIC ETHANOLISM, HEAVY SMOKER

POST GASTRECTOMY (6 MONTHS)

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 X No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time ot Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 X **Medtcal Examtner:** On the basis ot exemination end/or investigetion, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorthy C. Holworth, M.D.

29c. License number: D 06244

29d. Date signed (Month, Dey, Yeer): 1-15-01

30. Name and address of person who completed cause ot death (Item 23e) (Type, Print): DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863

State Registrar

31. Date tiled (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5 DQ

VOID

CERTIFICATE #

2001-02467

SEE

CERTIFICATE #

00-93612

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET ELSA STOFFREGEN ATHEY

2. Date of Death (Month, Day, Year): January 26, 2001

3. Time of Death: 10:43 PM

4a. Facility Name (If not institution, give street and number): 830 W. 40th Street, #655

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 063-14-3710

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 14, 1916

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 830 W. 40th Street, #655

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Residence

17. Father's Name (First, Middle, Last): Carl Henry Stoffregen

18. Mother's Name (First, Middle, Maiden Surname): Carolyn Eleanor Stumpf

19a. Informant's Name/Relationship (Type, Print): Susan E. Athey (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1505 LaBelle Avenue, Towson, Maryland 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery

Date: 1/29/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	14 days
Due to (or as a consequence of):	b. Cerebrovascular Accident	2 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Iredell W. Iglehart III MD

29c. License number: D33400

29d. Date signed (Month, Day, Year): January 29th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Iredell W. Iglehart III MD 500 W University Pkwy Baltimore, MD 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Albiker

2. Date of Death: Month January, Day 29, Year 2001

3. Time of Death: 11:40 AM

4a. Facility Name (If not institution, give street and number): Chapel Hill Nursing Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-14-6015

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 2, 1922

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimoe

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8624 Winands Road

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): William Zuby

18. Mother's Neme (First, Middle, Maiden Surname): Susan Urban

19a. Informent's Neme/Reletionship (Type, Print): Susan M. Miller Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2531 Old New York Avenue; Deland, Florida 32720

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Sacred Heart of Jesus — Date: 2/1/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Glioblastoma multiforme — 6 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D37573

29d. Date signed (Month, Day, Year): Jan 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Tibbell MD 25 Main St. Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02470

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RAYMOND L. ADAMS, Sr.
2. Date of Death: Month January Day 30 Year 2001
3. Time of Death: 7:35pm
4a. Facility Name (If not institution, give street and number): Baltimore VA Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: —

Funeral Director

5. Social Security Number: 572-28-2735
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 10, 1929
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4221 Hickory Avenue Apt. B
10f. Zip Code: 21211
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Burns International Security Company

17. Father's Name (First, Middle, Last): Ronald Tyler Adams
18. Mother's Name (First, Middle, Maiden Surname): Germaine Sansoucy

19a. Informant's Name/Relationship (Type, Print): Jacquelyn Welch Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10404 Apt B Barretts Delight Cockeysville MD 21030

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland VA Cemetery
Date: 2/5/01
20c. Location - City or Town, State: Garrison Forest, MD

21. Signature of Funeral Service Licensee: Tracy Henss Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multi. Organ System Failure — 12

Due to (or as a consequence of):
b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Agonal Aspiration

Due to (or as a consequence of):
d. Diverticulosis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: P13891
29d. Date signed (Month, Day, Year): January 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BEN LOWENTRITT 22 S. Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02471

AMEND#20a PER F.H. G792 2-1-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernice Autencio

2. Date of Death: Month 01 Day 25 Year 01

3. Time of Death: 3:15 Am

4a. Facility Name (If not institution, give street and number): Harford Gardens Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-74-3283

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): July 20, 1907

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4700 Harford Road

10f. Zip Code: 21214

10g. Citizen of What Country?: USA

11. Marital Status: unk
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Harford Gardens Nursing Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4700 Harford Rd Baltimore, MD 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION

Date: 2/1/01

20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Progressive decline

Due to (or as a consequence of):
b. Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Chronic kidney disease

Due to (or as a consequence of):
d. Anemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Prostate Calculus malnutrition

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rav

29c. License number: D 31464

29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shoaib A. Hafeez, 821 N. Eutaw St Suite 308, Balt. MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001

32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES C. BAUMGARTEN
2. Date of Death: Month JANUARY Day 26, Year 2001
3. Time of Death: 7:15 AM
4a. Facility Name (If not institution, give street and number): Heritage Harbour
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 235-38-5033
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27, 1926
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 149 Monticello Avenue
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): librarian
16b. Kind of Business/Industry: education

17. Father's Name (First, Middle, Last): John Contos
18. Mother's Name (First, Middle, Maiden Surname): Politime Triantafilopoulou

19a. Informant's Name/Relationship (Type, Print): Christina Fotos /sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 149 Monticello Ave Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: ▶ Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery disease
Due to (or as a consequence of):
b. Ischemic Cardiomyopathy — Yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ N. [illegible] M.D.
29c. License number: D41978
29d. Date signed (Month, Day, Year): 1-26-2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Nabil Tavakoli 9851 Greenbelt Rd #212 Lanham MD 20706.

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: ▶ Geneva B. Banks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02473

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: RENEE LIZARRAGA BAROWSKI

2. Dete of Death Month / Day / Year: JANUARY 28, 2001

3. Time of Death: 11:45 PM

4a. Facility Neme *(If not institution, give street and number)*: Stella Maris

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 138-64-4540

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: July 31, 1953

9. Birthplece *(State or Foreign Country)*: Peru

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1469 Charlestown Drive

10f. Zip Code: 21040

10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: housewife

16b. Kind of Business/Industry: none

17. Father's Neme *(First, Middle, Last)*: Aguirre Jorge Lizarrage

18. Mother's Neme *(First, Middle, Maiden Surname)*: Renee Galvez

19a. Informant's Neme/Reletionship *(Type, Print)*: Jesse Barowski/spouse

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1469 Charlestown Drive Edgewood, MD 21040

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removel from Stete 4☒ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)* | Dete | 20c. Location - City or Town, Stete

21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director

22. Neme end Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. UTERINE CANCER

Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or es a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)* | 28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier:

29c. License number: D43725

29d. Dete signed *(Month, Dey, Yeer)*: 1/29/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 0 1 2001

32. Registrer's Signeture: Renee B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JANUARY 28, 2001 11:45 p.m.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RENEE BAROWSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 02174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vivian M. Burton
2. Date of Death Month: 1 Day: 26 Year: 2001
3. Time of Death: 3:45 M
4a. Facility Name (If not institution, give street and number): 5660 A Woodmont Ave
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 129-07-1885
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-30-1915
9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 5660 A. Woodmont
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 3yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary
16b. Kind of Business/Industry: Schlumberge Law Firm

17. Father's Name (First, Middle, Last): John Burton
18. Mother's Name (First, Middle, Maiden Surname): Susan B. Allison

19a. Informant's Name/Reletionship (Type, Print): John Burton - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5660 A. Woodmont Ave Balto, Md 21239

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt Hope Cemetery
Date: 1-31-2001
20c. Location - City or Town, State: Hastings on the Hudson N.Y. N.Y.

21. Signature of Funeral Service Licensee: Mary K. Thompson
22. Name and Address of Facility: Mary F. A. West 5300 Wabash Ave Balto Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hypotension	
Due to (or as a consequence of): b.	Dehydration	2 days
Due to (or as a consequence of): c.	Dysphagia	3years
Due to (or as a consequence of): d.	Alzheimer's Disease	10years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown
23d. Deta of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Stroke
hypertension

23e. Did tobecco use contribute to the cause of death? 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

26a. Dete of Injury (Month, Day Year)
26b. Time of Injury M
26c. Injury et Work? 1☐Yes 2☐No
26d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
26f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner as steted. 2☐**Medical Examinar:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas J. Wilson MD
29c. License number: D40277
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Thomas J. Wilson MD, 5601 Loch Raven Blvd, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Dey, Yeer): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02475

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marian Bomhardt

2. Date of Death Month / Day / Year: February 01 2001

3. Time of Death: 12:21 AM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-34-3694

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 22 1936

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 40 Luke Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Household

17. Father's Name *(First, Middle, Last)*: Harry E. McGraw

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary G. Webster

19a. Informant's Name/Relationship *(Type, Print)*: John E. Bomhardt (spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 40 Luke Drive, Pasadena, MD. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Cemetery

Date: Feb 5 2001

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease — 6 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes Mellitus

Hypertension

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jonathan Forman MD

29c. License number: D0023811

29d. Date signed *(Month, Day, Year)*: 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Forman 1406B S. Crain Hwy #204 Glen Burnie MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02476

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PATRICIA BEHR

2. Date of Death — Month: 1 Day: 30 Year: 2001

3. Time of Death: 19:02

4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-30-7133

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: December 2, 1934

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14308 Lighthouse Avenue

10f. Zip Code: 21842

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent'a Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Retail

17. Father'a Neme *(First, Middle, Last)*: Charles C. Cook

18. Mother's Name *(First, Middle, Maiden Surneme)*: Lorraine Fouces

19a. Informent's Name/Reletionship *(Type, Print)*: David W. Behr-son

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: P.O. Box 260, Germantown, MD 20875

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☒ Other *(Specify)* Entombment

20b. Placa of Disposition *(Name of cemetery, crematory or other placa)*: Moreland Memorial Park

Data: 2/2/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: William G. Dau

22. Nama and Address of Facility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE METABOLIC ACIDOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MESENTERIC ISCHEMIA

Due to (or as a consequence of):

c. ATHEROSCLEROTIC DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: TAYLOR MD

29c. License number: P13997

29d. Dele signed *(Month, Day, Year)*: JANUARY 30 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MD TAYLOR, 22 SOUTH GREENE STREET, BALTIMORE, MARYLAND 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANN MERRILL BERMAN
2. Date of Death (Month, Day, Year): Jan 28, 2001
3. Time of Death: 7:40 pm
4a. Facility Name (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 578-07-5879
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 23, 1916
9. Birthplace (State or Foreign Country): VA

Usuet Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6210 PARK HEIGHTS AVENUE #200
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): LOUIS NATHANSON
18. Mother's Name (First, Middle, Maiden Surname): LENA NACHMAN
19e. Informent's Neme/Relationship (Type, Print): DAVID MERRILL / SON
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6210 PARK HEIGHTS AVENUE #200 - BALTIMORE, MD 21215
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 1/30/01
20c. Location - City or Town, Stete: WOODLAWN, MD
21. Signeture of Funeral Service Licensee: Mantell
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finet disease or condition resulting in death)
a. Cerebro Vascular Accident — Hours

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signature end title of certifier: Andres Salazar MD
29c. License number: D51051
29d. Date signed (Month, Day, Year): January 29, 2001
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 716 Maiden choice Lane, Catonsville, MD 21228

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Name: Ann Berman

State Registrar

31. Dete filed (Month, Day, Year): FEB 01 2001
32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GARRISON S. BELL

2. Date of Death: Month 01 Day 29 Year 2001

3. Time of Death: 11:50PM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 219-28-0181

6. Sex: 1 X M 2 ☐ F

7. Age (in yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 27 1934

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 7934 DUNHILL VILLAGE CIRCLE APT 203

10f. Zip Code: 21244

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 52/54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: HANDYMAN

17. Father's Name (First, Middle, Last): BERNARD BELL

18. Mother's Name (First, Middle, Maiden Surname): MILDRED SCOTT

19a. Informant's Name/Relationship (Type, Print): Jacqueline Lewis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Bowling Avenue, #23, Nashville, Tenn 37205

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 2-5-01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Charles D. Powell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 20 days

Due to (or as a consequence of): Bowel infarct — 30 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: AU417643512446

29d. Date signed (Month, Day, Year): 1/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BABAK MOSHOLDER 22 South Green St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02479

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EUGENE CARDER
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 4:45 am
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-2711
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 23, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Oldtown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 16501 Bible Hill Lane S.E.
10f. Zip Code: 21555
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: electrician
16b. Kind of Business/Industry: electrical
17. Father's Name *(First, Middle, Last)*: Fayett Earl Carder
18. Mother's Neme *(First, Middle, Maiden Surname)*: Mary E. Emrick
19a. Informant's Name/Relationship *(Type, Print)*: Margaret Carder/spouse
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 16501 Bible Hill Lane S.E. Oldtown, MD 21555
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Neme and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sepsis	15 days
Due to (or as a consequence ot):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Aspiration pneumonia	15 days
Due to (or as a consequence ot):		
	c. Neurogenic dysphagia	15 days
Due to (or es e consequence of):		
	d. Cerebrovascular accident	15 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, tactory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and menner steted.

29b. Signature end title of certifier: R. Barrera, Jr.
29c. License number: D 14865
29d. Date signed *(Month, Day, Year)*: January 30th 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-tranait

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN V. CAMPBELL

2. Date of Death (Month, Day, Year): JANUARY 28 2001

3. Time of Death: 1:50PM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-03-8107

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 27, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 8415 Bellona Lane

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: WWII

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): salesman

16b. Kind of Business/Industry: insurance

17. Fether's Name (First, Middle, Last): Oscar D. Campbell

18. Mother's Name (First, Middle, Maiden Surneme): Lillie M. Lutz

19a. Interment's Neme/Reletionship (Type, Print): Douglas Campbell/son

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 422 Hopkins Rad Baltimore, MD 21212

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [X] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)

Dete

20c. Location - City or Town, State

21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director

22. Name end Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

b. Respiratory Failure

Due to (or as a consequence of):

c. CHF

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD, Renal Failure, Atherosclerosis, Ischemic Bowel

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to compietion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner**: On the besis of exemineticn and/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) and menner steted.

29b. Signeture end Title of certifier: MD

29c. License number: D24569

29d. Dete Signed (Month, Dey, Yeer): 1/29/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): 515 Fairmount Ave, Suite 320, Towson, MD 21286

State Registrar

31. Dete filed (Month, Day, Year): FEB 01 2001

32. Registrer's Signeture

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

John Campbell

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LANE CARPENTER
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 8:05am
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 579-18-9820
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 1, 1921
9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 212 Lincoln Avenue
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mathematician
16b. Kind of Business/Industry: Johns Hopkins University

17. Father's Name (First, Middle, Last): Bryant M. Carpenter
18. Mother's Name (First, Middle, Maiden Surname): Myrle Clemens

19a. Informent's Name/Relationship (Type, Print): Elizabeth P. Carpenter/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 212 Lincoln Avenue Lutherville, MD 21093

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Gunpowder Friends Meeting
Date: 2-1-01
20c. Location - City or Town, State: Sparks, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert tailure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CONGESTIVE HEART FAILURE	< 24hrs
Due to (or as a consequence of):		
Sequentially list conditions, if eny, leeding to immedidate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. ACUTE MYOCARDIAL INFARCTION	< 24hrs
Due to (or es e consequence of):		
	c. CORONARY ATHEROSCLEROSIS	> 40 yrs
Due to (or es e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CEREBRAL AMYLOID ANGIOPATHY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [✓] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: John F Rogers MD
29c. License number: D16534
29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): JOHN F. ROGERS MD 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: per D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Carpenter, Lane B.

AB, 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02482

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Diane P. Cooper

2. Date of Death Month Day Year: January 29, 2001

3. Time of Death: 11:50 PM

4e. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-52-0946

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR 7, 1949

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 31 W. Elm Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Russell L. Slonaker, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred L. Webb

19a. Informant's Name/Relationship *(Type, Print)*: Deborah L. Cooper/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 159 Westtown Way, Apt. A202, West Chester, PA 19382

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: 1/30/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tariq

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 01/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

January 29, 2001 11:50 p.m.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Diane Cooper

RKD
01-0443-033
TRENITTA
COOPER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02483

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TRENITTA COOPER
2. Date of Death (Month, Day, Year): JANUARY 26, 2001
3. Time of Death: 9:05A.M.
4a. Facility Name (If not institution, give street and number): 638 AUDREY LANE
4b. City, Town, or Location of Death: OXON HILL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-96-5759
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-11-1977
9. Birthplace (State or Foreign Country): WASH. DC

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: OXON HILL
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 638 AUDREY LANE
10f. Zip Code: 20745
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMIN. CLERK
16b. Kind of Business/Industry: CHILDRENS HOSPITAL

17. Father's Name (First, Middle, Last): JEROME COOPER
18. Mother's Name (First, Middle, Maiden Surname): YVONNE PORTER

19a. Informant's Name/Relationship (Type, Print): YVONNE PORTER - MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 RHODE ISLAND AVE., NW WASH., DC 20001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK
Date: 02-02-01
20c. Location - City or Town, State: LANDOVER, MD

21. Signature of Funeral Service Licensee: B.C Taylor
22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. GUNSHOT Wounds of HEAD and left HAND
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 1/26/01
28b. Time of Injury: 9:00 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SUBJECT WAS SHOT
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 638 Audrey Lane Apt 203 OXON HILL, MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. M. Titus
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 27, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2001 JAN 32 AM 2:23

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathryn Griffith Cornell
2. Date of Death (Month, Day, Year): January 31 2001
3. Time of Death: 10:35AM
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-12-3069
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 31, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 22 Regester Ave.
10f. Zip Code: 21212
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): secretary
16b. Kind of Business/Industry: college

17. Father's Name (First, Middle, Last): John Edwin Griffith
18. Mother's Name (First, Middle, Maiden Surname): Kathryn Harlan

19a. Informant's Name/Relationship (Type, Print): William Cornell/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1703 South Rd. Baltimore, MD 21209

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 2/1/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John C. Mitchell IV
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 13 d

Due to (or as a consequence of): COPD — 15 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION; LUNG CANCER

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nathan Rosenblum MD
29c. License number: D23319
29d. Date signed (Month, Day, Year): JANUARY 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATHAN ROSENBLUM MD 7600 OSLER DRIVE TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KATHRYN CORNELL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02485

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SAMI COCILOVA
2. Date of Death Month Day Year: JANUARY 29,01
3. Time of Death: 5:35 PM
4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-18-3109
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 17,1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lochearn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6854 Westridge Road
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unk; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Warehouse Supervisor
16b. Kind of Business/Industry: Electrical Supplies

17. Father's Name *(First, Middle, Last)*: Frank Cocilova
18. Mother's Name *(First, Middle, Maiden Surname)*: Adalina DeLuca

19a. Informant's Name/Relationship *(Type, Print)*: JoAnne Westwood Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5658 Kavon Avenue; Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery | Date: 2/3/01
20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: John Evans
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC ESOPHAGEAL CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY BYPASS GRAFT
PROSTHETIC AORTIC VALVE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K.S. RAO. M.D.
29c. License number: 047462
29d. Date signed *(Month, Day, Year)*: JANUARY 29, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S. RAO. M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Goldie COXSON

2. Date of Death Month: January Day: 27 Year: 2001

3. Time of Death: 8:20 pm

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219 40 3857

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB.4,1942

9. Birthplace (State or Foreign Country): maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2238 W. LEXINGTON STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH

College (1-4or 5+): 2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INQUIRY STAFF SPECIALIST

16b. Kind of Business/Industry: SOCIAL SECURITY

17. Father's Name (First, Middle, Last): CLEVELAND ATKINSON

18. Mother's Name (First, Middle, Maiden Surname): AMELIA Mc CLAIN ATKINSON

19a. Informant's Name/Relationship (Type, Print): CLIFTON Mc CLAIN (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4516 PEN LUCY ROAD BALTO.,MD. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): king memorial park Date: 2/3/2001

20c. Location - City or Town, State: RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn

22. Name and Address of Facility: LEWIS T. GWYNN FUNERALHOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO. ,MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Breast cancer with metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Did not order dialysis information

Diabetes

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Alice Hsieh

29c. License number: H43974

29d. Date signed (Month, Day, Year): January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alice Hsieh Northwest Hospital Randallstown, Md

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#27,29a perPHYG792 2/1/2001 EW

Certificate of Death

Reg. No. 2001 02487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
BENNIE COWAN	01	02	2001	1:25 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George Hospital Center	Cheverly	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
072-20-9771	1☐ M 2☒ F	99 Yrs.					Sept 30, 1901	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Cheverly	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2900 Mercy Lane	20785	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	nutritionist	hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Pickens	Maggie Pickens

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward Holland/great nephew	6613 Springcrest Dr Greenbelt, MD 20770

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disaasa or condition resulting in death)	a. Sepsis	Days_ WKS
Due to (or as a consequence of):	b. Pnumonia	WKS
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last — Due to (or as a consequence of):	c. Decubitus ulcer	WKS-Month
	d. organic Brain Syndrom	WKS-month

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Anemia

23b. Did tobacco use contributa to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Was case refarred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end manner as steted.

2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier	29c. Licansa number	29d. Data signad (Month, Day, Year)
M.D.	D0056184	01.02.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JALAL SAIED, M.D. 3001 Hospital Drive, cheverly, MD. 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 1 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#7 perFHG792 2/1/2001 EW

Certificate of Death

Reg. No. 2001 02488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HOWARD CARRICK

2. Date of Death: Month 01 Day 30 Year 01

3. Time of Death: 1:55 PM

4a. Facility Name (If not institution, give street and number): MARINER NORTH

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: A.A

Funeral Director

5. Social Security Number: 212.12.1065

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 ~~81~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 26, 1920

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 111 RIDGELY RD. GLEN BURNIE

10f. Zip Code: 21061

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Yaer or Deteas: 43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR

16b. Kind of Business/Industry: OLIN CHEMICAL

17. Father's Name (First, Middle, Last): HOWARD W. CARRICK, SR.

18. Mother's Name (First, Middle, Meiden Surneme): ELIZABETH BALENTINE

19a. Informant's Name/Reletionship (Type, Print): MARY R. CARRICK WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 111 RIDGELY RD GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): CROWNSVILLE VET CEM | Dete: 2FEB01

20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: K. GREGORY FINK MO 1148

22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	ASPIRATION PNEUMONIA	1 day
Due to (or es a consequenca of): b.	STROKE	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or es e consequence of): c.	ATHEROSCLEROSIS	
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in tha underlying cause given in Part I.: MULTI INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streel, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, date and place, and due to tha cause(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end litla of certifier: Richard E Fisher

29c. License number: D02519

29d. Data signed (Month, Day, Year): Jan - 31 - 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard E Fisher 4710 PENNINGTON AVE 21226

State Registrar

31. Data filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Penna G. Spades

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS G. CHILDRESS
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 1030 pm
4a. Facility Name (If not institution, give street and number): 6915 GOUGH STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-20-9410
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 6, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6915 GOUGH STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: '43-'46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CABLE TECHNICIAN
16b. Kind of Business/Industry: WESTERN ELECTRIC

17. Father's Name (First, Middle, Last): ARTHUR R. CHILDRESS, SR.
18. Mother's Name (First, Middle, Maiden Surname): ANNA R. OLMER

19a. Informant's Name/Relationship (Type, Print): FRANCIS B. CHILDRESS-SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8298 BARRYFIELD DRIVE BALTIMORE, MARYLAND 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY | Date: 1/31/01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Elizabeth Selinski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. CARCinoma of colon with metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic pancreatitis + malnutrition

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mesbah Dowla
29c. License number: D15085
29d. Date signed (Month, Day, Year): 01-31-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MESBAH DOWLA, M.D. 98 N. Broadway St 409 Balto Md 21231

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001
32. Registrar's Signature: ▶ D. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a.,bper phys.,G792,02/01/01dhb

Certificate of Death

Reg. No. 2001 02490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin Jess Culp
2. Date of Death: Month: Jan. Day: 5 Year: 2001
3. Time of Death: 1:00 A.M.
4a. Facility Name (If not institution, give street and number): 12302 Shadow Lane
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 209 22 4037
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 24, 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12302 Shadow Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 50-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurant Owner
16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Jesse Melvin Culp
18. Mother's Name (First, Middle, Maiden Surname): Elsie Gick

19a. Informant's Name/Relationship (Type, Print): Suzanne Peterson Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12415 Sandal Lane Bowie Maryland 20715

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery Date: Jan. 10, 2001
20c. Location - City or Town, State: Cheltenham Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Prostate Cancer — 8-10-2000
Due to (or as a consequence of):
~~Dictated on 1/4/2001~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Wang
29c. License number: D0054689
29d. Date signed (Month, Day, Year): 1-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Wang MD 3231 Superior Lane Ste Bowie Md

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at this

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ADH
UNKNOWN 01-0429-510
01-020

JACQUELINE DAVIS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEMS# 23a, 27, 28a-f per M.E. G792 020201 SS

Reg. No. 2001 02491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jacqueline F. Davis
2. Date of Death: Month JANUARY Day 25, Year 2001
3. Time of Death: 2245 PM
4e. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-60-2655
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1964
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 16 Monroe St.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Reca - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping
16b. Kind of Business/Industry: Building
17. Father's Name (First, Middle, Last): Charles F. Davis
18. Mother's Name (First, Middle, Maiden Surname): Otella Campbell
19a. Informant's Name/Relationship (Type, Print): Charlene Haulard
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6137 Marquette Rd. Apt. H Balto, MD 21206
20a. Method of Disposition: 1☐ Buriel 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other plece): Metro Crematory Date: 2-3-01
20c. Location - City or Town, State: Catonsville, MD.
21. Signature of Funeral Service Licensee: Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, of complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ALCOHOL, COCAINE AND NARCOTIC INTOXICATION
Due to (or as a consequenca of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causes of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No
25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Dey Year): found: 1/25/01
28b. Time of Injury: 9:30p M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Other residence
28f. Location (Street end Number or Rural Route Number, City or Town, State): Baltimore, MD 22 N. Monroe St.
29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore McKinney MD
29c. License number: OCME
29d. Dete signed (Month, Dey, Year): JANUARY 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE McKinney 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): FEB 0 1 2001
32. Registrer's Signature: D. Smith

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY L. DAVIS
2. Date of Death (Month, Day, Year): JAN 20 2001
3. Time of Death: 11:35 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 225-24-2809
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 8, 1925
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 908 Hudson Avenue #4
10f. Zip Code: 20912
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): factory worker
16b. Kind of Business/Industry: plastics

17. Father's Name (First, Middle, Last): James. W. R. Michael
18. Mother's Name (First, Middle, Maiden Surname): Pearlie E. Wichael

19a. Informant's Name/Relationship (Type, Print): Barbara Trageser/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 Betsy Bell Rd 1st flr Stanton, VA 24401

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Acute Respiratory Failure
Due to (or as a consequence of):
b. NON Small Cell Lung CANCER
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. End Stage COPD
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mahnaz Parveen
29c. License number: D45692
29d. Date signed (Month, Day, Year): Jan 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHNAZ PARVEEN MD 1500 Forest Glen Rd Silver Spring MD 20910

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02493

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elisha Walker Dunker, Jr.

2. Date of Death Month Day Year: January 29, 2001

3. Time of Death: 11:00 PM

4a. Facility Name *(If not institution, give street and number)*: Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-16-9079

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 10, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 303 4th Avenue S.W.

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Manager

16b. Kind of Business/Industry: Heating/ Air Conditioning

17. Father's Name *(First, Middle, Last)*: Elisha W. Dunker, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Huber

19a. Informant's Name/Relationship *(Type, Print)*: Anita Dunker/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 303 4th Avenue S.W. Glen Burnie, MD 21061

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 1-31-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Lower Gastrointestinal Bleed	12 hrs
Due to (or as a consequence of): b.	Ischemic Colitis	6 mo.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Intracerebral Hemorrhage

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tredell W Iglehart III MD

29c. License number: D33400

29d. Date signed *(Month, Day, Year)*: January 30th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tredell W. Iglehart III MD 500 W University Pkwy Baltimore MD 21210

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Elisha Dunker 1-29-01 11 pm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02494

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Devon Matthew David

2. Date of Death Month / Day / Year: January 27 2001

3. Time of Death: 4:25 am

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 265 11 1705

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26 1949

9. Birthplace *(State or Foreign Country)*: Westchester, PA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County - Pikesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4218 Colonial Road

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yaer or Datas: Vietnam

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4

16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Residential Supervisor

16b. Kind of Business/Industry: Maryland School for the Blind

17. Father's Name *(First, Middle, Last)*: Nehemiah Clark David

18. Mother's Name *(First, Middle, Maiden Surnama)*: Julia Irene Wooley

19a. Informent's Name/Relationship *(Type, Print)*: Wellington B Snow II

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 843 West 34th Street Baltimore, Maryland 21211

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of camatery, cramatory or othar place)*: Forest Lawn Gardens Cem. — Data: February 1,2001

20c. Location - City or Town, State: Ocala, Florida

21. Signetura of Funerel Service Licensee: ▶ Heather Lassahn Chomack

22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MALIGNANT MELANOMA

Due to (or as a consequence of):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

b. Due to (or es e consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred el the time, date end piece, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: ▶

29c. License number: D43225

29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and addreas of person who completed ceuse of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 0 1 2001

32. Registrar's Signature: ▶ Lawrence G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

JANUARY 27, 2001 4:25 a.m.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

DEVON DAVID

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

98-641

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID, R Dorff

2. Date of Death: Month 01, Day 30, Year 2001

3. Time of Death: 7:28AM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 217-76-2052

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1958

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 11003 Grace Corner Rd.

10f. Zip Code: 21811

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 yrs. College (1-4or 5+): 2 yrs.

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Night Auditor

16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): Arlo Dorff

18. Mother's Name (First, Middle, Maiden Surname): Helen Barton

19a. Informant's Name/Relationship (Type, Print): Deborhra Dorff (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11003 Grace Corner Rd. Berlin, Maryland 21811

20a. Method of Disposition: 1 [ ] Burial [X] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Metro Crematory Inc. Date: 2-2-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Neme and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or raspiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in deeth) a. Sepsis

Due to (or as a consequence of): Pneumonia

Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last

b. Due to (or es a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledge, daath occurred et the time, date and place, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data end placa, and dua to the cause(s) and manner steted.

29b. Signature and title of certifier

29c. License number: P13397

29d. Date signed (Month, Dey, Year): 1/3-/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): BABAK MOEINDOLKI 22 South greene street BALTIMORE Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): FEB 01 2001

32. Registrar's Signature: Geneva D. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Earle
2. Date of Death: Month January, Day 24, Year 2001
3. Time of Death: 9:45 AM
4a. Facility Name (If not institution, give street and number): 304 Holly Hill Road
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-46-1690
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1920
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 304 Holly Hill Road
10f. Zip Code: 21136
10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker
16b. Kind of Business/Industry: State Department of Health & Human Services

17. Father's Name (First, Middle, Last): Charles Oscar Tittle
18. Mother's Name (First, Middle, Maiden Surname): Clara Frances Hanson

19a. Informant's Name/Relationship (Type, Print): Byron E. Earle Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Holly Hill Road; Reisterstown, Maryland 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Garrison Forest Veteran
Date: 1/30/01
20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: John Hoover
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Julie Mincone
29c. License number: D27123
29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julie Mincone 70 Main St Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02497

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNE C. EVANS

2. Date of Death (Month, Day, Year): JANUARY 29, 2001

3. Time of Death: 11:15AM

4a. Facility Name *(If not institution, give street and number)*: 811 E. 22ND STREET

4b. City, Town, or Location of Death: BALTO.

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-6524

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-28-1928

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 811 E. 22ND STREET

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COMPUTERS

16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name *(First, Middle, Last)*: BURREL JONES

18. Mother's Name *(First, Middle, Maiden Surname)*: MARIE PRYOR

19a. Informant's Name/Relationship *(Type, Print)*: MELVIN R. TERRY, SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4712 OLD YORK RD, BALTO. MD 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL PK

Date: 2-2-01

20c. Location - City or Town, State: ARBUTUS, MD

21. Signature of Funeral Service Licensee: ▶ William E Howell Jr.

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. uremia — 1 month

Due to (or as a consequence of):

b. end stage renal disease — 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. hypertension — >10 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Shannon Putman MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shannon Putman 1830 East Monument Street, Room 9020, Baltimore, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02498

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Mary Engle

2. Date of Death Month / Day / Year: January 26, 2001

3. Time of Death: 1:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: Riverview Nursing Home

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 214-01-5498

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 101 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 12, 1899

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 621 S. Lehigh Street

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Her own home

17. Father's Name *(First, Middle, Last)*: Louis Schmitt

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Cohast

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Marion Schell - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7 Wethersfield Drive New Freedom, PA 17349

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Oak Lawn Cemetery

Date: 1/29/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Elizabeth Selinski

22. Name and Address of Facility: Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, MD 21224

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)

a. Congestive Heart Failure — Few weeks

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure.

Osteo arthritis

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Michael Swiontek MD

29c. License number: D19667

29d. Date signed *(Month, Day, Year)*: 01-28-2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Michael Swiontek MD 7310 Ritchie Highway Suite 508 Glen Burnie MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 1 2001

32. Registrar's Signature: Penny D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02499

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ISABELL S. FRESEN

2. Date of Death Month Day Year: JANUARY 29, 2001

3. Time of Death: 12:10 AM

4a. Facility Name (If not institution, give street and number): National Lutheran Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 523-32-5031

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 100 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 7, 1900

9. Birthplace (State or Foreign Country): Wyoming

Usual Residence of Decedent

10a. State: MD

10b. County: Mongtomgery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 9701 Veirs Drive

10f. Zip Code: 20850

10g. Citizen of What Country: USA

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decadent's Education (Specify only highest grede completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): special education teacher

16b. Kind of Business/Industry: education

17. Father's Name (First, Middle, Last): Wright Scofield

18. Mother's Name (First, Middle, Meiden Surname): Agnes Bruce

19e. Informant'a Name/Relationship (Type, Print): Nancy Whitney/daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 16733 Shea Lane Gaithersburg, MD 20877

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removel from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 10 days

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other signiticant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Osteoporosis

Venous insufficiency

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end titie of certifier

29c. License number: D50061?

29d. Dete signed (Month, Day, Year): January 29, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): SAMUEL MALLER MD

State Registrar

31. Dete filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: Aftar this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as tha burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Burke Fox
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 1900
4a. Facility Name (If not institution, give street and number): Chesapeake Hospice House
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 137-20-6008
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 12, 1928
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1009 Boom Court
10f. Zip Code: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1950-1953
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Research Chemist
16b. Kind of Business/Industry: Naval Research U.S. Government

17. Father's Name (First, Middle, Last): Clifford William Fox
18. Mother's Name (First, Middle, Maiden Surname): Alma Sutterman

19a. Informant's Name/Relationship (Type, Print): Warren W. Schultz / Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4056 Cadle Creek Road Edgewater, MD 21037

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation — Date: 01-28-01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ B. O
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 4 mo nths
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kevin Knapp MD
29c. License number: D30051301
29d. Date signed (Month, Day, Year): January 31 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin Knapp, MD 900 Bestgate Rd. #300 Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: ▶ Brenda G. Sparks

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